STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385237	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fernhill Rehabilitation and Care	5737 NE 37th Avenue Portland, OR 97211

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review it was determined the facility failed to provide resident council members with responses to concerns identified in resident council for 2 of 4 meetings reviewed for resident council. This placed residents at risk for delays in addressing care related concerns and diminished quality of life. Findings include:A 2/2021 Resident Council facility policy states, A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern.Resident Council meeting records from 2/25/25 included concerns discussed in the following areas:- residents not receiving toe nail care,- laziness of staff, - cleanliness of the facility on weekends,- care conferences not being provided, - snacks not being assessable at night,- challenges with being able to go outside,- food being cold, and- wanting more fresh fruit.Resident Council meeting records from 7/28/25 included concerns discussed the following areas:- doing community outings,- clothing being lost in laundry,- call lights not being answered, and- not responding to or belittling resident concerns. Review of Resident Council meeting records dated 2/25/25 and 7/28/25 revealed the facility did not address and of the concerns reported during those meetings. No verbal or written responses to the identified concerns were provided to Resident Council members.On 8/7/25 at 10:27 AM Staff 6 (Activities Director) stated she assisted with recording concerns from Resident Council meetings and provided the information to the appropriate department. Staff 6 stated she did not receive any response from staff. On 8/7/25 at 11:32 AM during a Resident Council interview with Resident 2, Resident 24 and Resident 41, the residents stated they identified areas of concern and provided information in writing regarding those concerns to Staff 6 but had not received any response regarding the identified concerns. On 8/7/25 at 12:26 PM Staff 2 (DNS) stated she had not received any information regarding concerns communicated by Resident Council on 7/28/25. On 8/7/25 at 1:05 PM Staff 12 (Dietary Manager) stated she responded verbally with regards to snacks but was not instructed to provide a written response to Resident Council's concerns. On 8/7/25 at 12:54 PM Staff 20 (Housekeeping Manager) stated she had never received any information from the Resident Council regarding laundry concerns.On 8/7/25 at 2:01 PM Staff 1 (Administrator) stated concerns raised during Resident Council meetings were discussed verbally among staff. Staff 1 confirmed no direct communication was provided to the Resident Council regarding the 2/25/25 and 7/28/25 meetings.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to provide a homelike environment for 2 of 3 hallways reviewed for environment. This placed residents at risk for a lack of homelike environment. Findings include:1. Resident 36 admitted to the facility in 2024 with a diagnosis including congestive heart failure. A 5/9/25 Annual MDS assessed Resident 36 with a BIMS score of 14 which indicated she/he was cognitively intact. During an observation on 8/4/25 at 3:22 PM a personal fan located on the bedside table of Resident 36 and was noted to have a thick, visible accumulation of dust, lint, and grime coating the fan blades. and protective grill. The buildup appeared grey in color, layered, and had visibly adhered to the surfaces. On 8/5/25 at 10:58 AM Resident 36 stated she/he wanted her/his fan cleaned and had been waiting for staff to clean it. On 8/5/25 at 11:23 AM Staff 20 (Housekeeping Supervisor) stated housekeepers were responsible to clean resident’s personal fans. On 8/5/25 at 11:27 AM Staff 1 (Administrator) observed Resident 36’s personal fan, confirmed it needed to be cleaned and stated he expected all personal fans to be clean. 2. Observations on 8/4/25 through 8//7/25 between the hours of 9:00 AM and 4:00 PM revealed the following: -room [ROOM NUMBER]: The walls to the left and across from bed D had numerous scrapes and areas that required painting, the closet was scraped and had residual masking tape on the door and there were missing pieces of wood on the left portion of the bottom closet drawer which were uncleanable. There were multiple holes in the wall to the right of the hand sanitizer dispenser. The center bed area had a large, patched area near the electric outlet that required painting. The wall at the head of bed W had deep scrapes needing repair. -room [ROOM NUMBER]: The walls behind and to the right of the head of bed were scraped, the wall under the window had multiple vertical scrapes and there were multiple screws in the wall across from the bed. -room [ROOM NUMBER]: There were multiple scrapes on the heater, nails and screws in the walls to the left of the bed, and splashes and streaks of an unknown substance at the head of and beside the bed. The vent in the ceiling above the resident was covered in dust build-up, the resident's bedside table was sticky, and the wheels stuck when attempting to move the table. On 8/4/25 at 9:52 AM and 11:31 AM, Resident 17 (room [ROOM NUMBER]) stated they don't clean anything for me. Resident 17 and Resident 52 (room [ROOM NUMBER]) both stated their rooms required cleaning and repairs and the rooms were not homelike. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/25 at 9:32 AM, Staff 11 (Maintenance Director) stated each resident room needed repairs, painting and updating and confirmed the resident rooms identified were not homelike. On 8/7/25 at 12:30 PM, Staff 1 (Administrator) stated he expected resident rooms to be homelike and confirmed the identified resident rooms required attention.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review it was determined the facility failed to provide a written grievance resolution or communicate with a resident or resident's representative regarding the resolution of a resident grievance for 1 of 3 (#36) sampled residents reviewed for personal property. This placed residents at risk for unaddressed concerns and grievances. Findings include:The facility's 6/1/25 Resident Grievance & Investigation Policy & Procedure directed residents and staff to complete a grievance form with concerns. Grievances were to be conducted and documented on the Resident Grievance Investigation Form with in five working days. Grievances would be documented on a grievance form and kept in a binder to track and trend concerns Resident 36 was admitted to the facility in 2024 and had diagnoses including depression and anxiety. A 5/9/25 Annual MDS indicated Resident 36 had a BIMS score of 14 which indicated she/he was cognitively intact. On 8/4/25 at 3:17 PM Resident 36 stated she/he had multiple items that were missing and no one did anything about it. The resident stated staff were very aware she/he had concerns of the missing items. The resident expressed no knowledge if these items were being investigated or any resolutions. On 8/5/25 at 4:07 PM the Grievance binder was reviewed for Resident 36's possible grievances. The binder was reviewed from 1/2025 through 8/2025 and revealed four grievances by Resident 36. The Resident Grievance Forms failed to provide resolutions to the concerns, no signatures and no evidence the resident was notified of the investigation. On 8/7/25 at 3:16 PM Staff 10 (Social Services Director) acknowledged she was responsible for following up on the resident grievances. Staff 10 stated the grievances were a work in process and confirmed Resident 36's grievance forms were incomplete and she was not able to provide evidence the resident was notified of the results of any the grievances. On 8/7/25 at 3:25 PM Staff 1 (Administrator) stated he expected all resident grievances to receive a response within five days and the forms should be completed thoroughly to allow for effective trend tracking. He acknowledged the facility had not followed the resident grievance process to investigate concerns and provide residents with documented outcomes.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review it was determined the facility failed to protect the resident's right to be free from physical abuse by Resident 27 for 1 of 4 sampled resident (#24), reviewed for abuse. This placed residents at risk for additional physical abuse. Findings include:Resident 27 admitted to the facility in 2018 with a diagnosis including a stroke.Resident 24 admitted to the facility in 2024 with diagnoses including depression, scoliosis (abnormal spine).The facility's 1/3/25 Investigation summary concluded from Resident 24's statement she/he woke around 4:00 AM on 12/31/24 and saw Resident 27 in her/his room. When Resident 24 tried to stand up, Resident 27 pushed her/him down onto the bed and proceeded to hold the door shut from the outside. Resident 24 called the police and told staff what had happened.On 8/7/25 at 1:48 PM Staff 1 (Administrator) confirmed physical abuse occurred when Resident 27 pushed Resident 24 onto the bed on 12/31/24. Staff 1 stated all residents were to be free from any type of abuse.

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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 interviews and record review it was determined the facility failed to report allegations of physical abuse within the mandated timeframe for 1 of 4 sampled residents (#24) for 1 of 2 Facility Reported Incident (FRI) reports reviewed for abuse. This placed residents at risk for further abuse. Findings include:The facility's revised 4/2021 Abuse, Neglect, Exploitation or Misappropriation Prevention Program policy and procedure directed staff to report allegations of abuse within the required timeframes.On 12/31/24 at 11:11 AM, the state agency (SA) received a FRI for the 12/31/24 at 4:00 AM alleged abuse of Resident 24 by Resident 27. The FRI revealed Resident 27 entered Resident 24's room and pushed her/him onto her/his bed, then left and held the door shut from the outside so Resident 24 could not leave the room.On 8/7/25 at 1:48 PM Staff 1 (Administrator) stated he was not informed of the incident until his morning meeting approximately 9:30 AM. He confirmed the incident occurred and staff were aware of the incident at 4:00 AM on 12/31/25. Staff 1 acknowledged the FRI was submitted late to the State Agency (SA).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview and record review it was determined the facility failed to ensure accurate MDS assessments were completed for 1 of 1 sampled resident (# 41) reviewed for dental. This placed residents at risk for an inaccurate picture of the resident's status. Findings include:Resident 41 was admitted to the facility in 4/2020 with diagnoses including a stroke. On 8/4/25 at 10:28 AM and 8/6/25 at 1:46 PM, Resident 41 was observed to have no upper teeth and missing molars on both sides of the lower jaw with observed difficulty chewing some food textures including cucumbers and large pieces of lettuce. Resident 41 reported she/he had missing upper teeth with three broken tooth fragments and missing teeth on both sides of her lower mouth. Resident 41 stated she had difficulty chewing hard food items. Resident 41's 7/14/25 Quarterly MDS indicated Resident 41 had no cognitive impairment and no difficulty chewing food. Resident 41's 4/13/25 Annual MDS indicated Resident 41 had no cognitive impairment and Resident 41 had no natural teeth or tooth fragments, no obvious or likely broken natural teeth and no difficulty chewing. On 8/7/25 at 10:38 AM, Staff 2 (DNS) verified Resident 41's MDS' were inaccurate and stated her expectation was Resident 41's MDS assessments were correct and accurately reflected the resident's dental status.

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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 observations, interviews and record review it was determined the facility failed to implement a comprehensive person-centered care plan for 1 of 2 sampled residents (#3) reviewed for accidents. This placed residents at risk for injury related to falls. Findings include:Resident 3 was admitted to the facility in 5/2025 with diagnoses including chronic kidney disease and dementia.A 7/9/25 Significant Change MDS and associated CAA's revealed Resident 3 had experienced falls since admission and her/his functional and cognitive decline placed them at increased risk for injury related to falls.The 7/23/25 Care Plan identified the intervention to have Resident 3's call light within reach and encourage her/him to use it for assistance.On the following occasions Resident 3's call light was observed to be out of reach: -8/5/25 at 8:38 AM-8/5/25 at 3:12 PM-8/6/25 at 8:48 AM-8/6/25 at 10:14 [NAME] 8/5/25 at 8:07 PM Staff 7 (CNA) stated Resident 3 experienced recent falls and knew how to use the call light appropriately.On 8/6/25 at 10:15 AM Staff 8 (CNA) stated Resident 3 experienced more falls recently and that he rounded on the resident hourly. Staff 8 stated he ensured Resident 3's call light was within reach and reminded her/him to use it for help. When Staff 8 entered Resident 3's room while the resident was in bed, they acknowledged the call light was on the floor.On 8/6/25 at 11:25 AM Staff 4 (LPN RCM) stated staff was expected to check for location of call lights every time they were in a resident's room. Staff 4 acknowledged call lights should always be within residents' reach.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview and record review, it was determined the facility failed to provide an ongoing program to support individual activity interest and preferences for 1 of 1 sampled resident (#36) reviewed for activities. The failure to provide meaningful and preferred activities placed residents at risk for unmet psychosocial needs. Findings include:Resident 36 admitted to the facility in 2024 with a diagnoses including anxiety and major depression.Resident 36's 5/9/25 Annual MDS assessed her/him as cognitively intact. Resident 36 was assessed with leisure interest of the following importance to her/him: Very important: outside to fresh air; to do your favorite activities. Somewhat important: do things with groups of people; pets; listen to music. Not very important: Religious; news; books/reading materials.Resident 36's 3/26/25 Activity admission Assessment (readmission) assessed her/him as completely independent in her/his leisure pursuits, and enjoyed music, walking/wheeling outdoors, watching television, talking, helping others, and to vote.On 8/4/25 at 3:21 PM Resident 36 stated she/he was often bored and nothing on the group calendar interested her/him except Bingo. Resident 36 stated she/he did not have any music to listen to in the room but could watch television. The 8/6/25 care plan for Resident 36 directed staff to assist with one-on-one Chaplin visits, she/he was a Christian, liked to watch television, hunting and fishing interests, socializes with others and to invite to Bingo group. Multiple observations were made between 8/5/25 at 1:37 PM to 8/7/25 at 2:00 PM of Resident 36 not involved in leisure activities or a Bingo group.Review of Resident 36's activity participation from 7/5/25 to 8/6/25 revealed she/he had attended one Bingo group, attended an unidentified group, went outside two times, participated in individual activities on two occasions.On 8/7/25 at 3:54 PM Staff 6 (Activity Director) confirmed Resident 36 was identified as religion not being important to her/him and was care planned for religious activities. Staff 6 acknowledged the lack of documentation for Resident 36 for activity participation. Staff 6 stated it was difficult to plan activities to keep the interests of all residents.On 8/7/25 at 4:24 PM Staff 1 (Administrator) stated he expected personalized activities to be provided for each resident and acknowledged the need for improvement in this area to increase resident engagement. Staff 1 stated he expected resident participation in activities to be documented.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview and record review it was determined the facility failed to obtain vision services for 1 of 1 sampled resident (#41) reviewed for vision. This placed residents at risk for not adequately addressing vision related needs. Findings include:The facility's Care of the Visually Impaired Resident policy, dated 3/2021, indicated it was the facility's responsibility to assist the resident and representatives in locating available resources, scheduling appointments and arranging transportation to obtain needed services. Resident 41 was admitted to the facility in 4/2020 with diagnoses including a stroke and diabetes. A 3/4/25 Ocular (related to the eyes) Progress Note completed by the facility optometrist (an eye care specialist) indicated Resident 41 was referred to a retina specialist (a medical doctor specializing in the diagnoses and treatment of eye diseases and conditions) on 2/1/24 but the resident was not seen by a specialist. Recommendations instructed the facility to follow-up regarding Resident 41's 2/1/24 referral because the resident reported a continual decline in her/his vision. Resident 41's 4/13/25 Annual MDS indicated the resident had no cognitive impairment and Resident 41 wore corrective lenses and was able to see in adequate light with glasses or visual appliances. Resident 41's 5/19/25 impaired visual function care plan indicated staff would arrange a consultation with an eye care practitioner as required. A review of Resident 41's electronic health record revealed no evidence Resident 41 was scheduled with or seen by a retina specialist. On 8/4/25 at 10:28 AM and 8/7/25 at 8:17 AM Resident 41 stated, for the past four months, she/he had been asking Staff 10 (Social Service Director) to schedule an appointment with an eye doctor because she/he had diabetes and, my eyes are getting really bad. Resident 41 was observed wearing glasses and stated she/he bought several pairs of reading glasses but had no prescription glasses. On 8/5/25 at 2:05 PM, Staff 10 stated she was aware Resident 41 wanted to see an eye doctor because the resident's vision was not great. Staff 10 confirmed no appointment with an eye doctor was scheduled for Resident 41. On 8/7/25 at 10:30 AM, Staff 2 (DNS) confirmed Resident 41 was not scheduled for an appointment with an eye doctor.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review it was determined the facility failed to the ensure the DCSDR (Direct Care Staff Daily Report) postings were accurate for 15 of 45 days reviewed for staffing. This placed residents and visitors at risk for inaccurate staffing information. Findings include:Review of the facility's DCSDRs from 6/30/25 through 8/4/25 revealed 15 of 45 days reviewed were inaccurate or incomplete. Issues included, missing or incomplete licensed nurse staff hours, no CNA hours listed, missing census data, incorrect dates, and missing signatures. These deficiencies were noted on the following dates: 6/30/25, 7/2/25, 7/3/25, 7/9/25, 7/11/25, 7/15/25, 7/25/25, 7/26/25, 7/29/25, 7/30/25, 7/31/25, 8/1/25, 8/2/25, 8/3/25 and 8/4/25.On 8/7/25 at 3:55 PM, Staff 15 (Human Resources/Staffing Coordinator) reviewed the 6/30/25 through 8/4/25 DCSDRs and verified the reports were inaccurate or incomplete on the days identified.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview and record review it was determined the facility failed to obtain dental services for 1 of 1 sampled resident (#41) reviewed for dental services. This placed residents at risk for unaddressed dental care needs. Findings include:The facility's Dental Services policy, dated 3/2021, indicated the following: -The social services representative would assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. -All dental services provided were recorded in the resident's medical record. Resident 41 was admitted to the facility in 4/2020 with diagnoses including a stroke and diabetes. Resident 41's 4/13/25 Annual MDS indicated the resident had no cognitive impairments. Resident 41's 5/19/25 oral/dental health care plan indicated the resident was missing her/his top teeth and the majority of her/his lower teeth. Interventions included coordinating arrangements for dental care and transportation as needed/ordered. A review of Resident 41's electronic record revealed no evidence the resident was seen by a dentist. On 8/4/25 at 10:28 AM and 8/7/25 at 8:17 AM Resident 41 was observed with no upper teeth and only a few lower front teeth which appeared chipped and worn. Resident 41 stated, for the past four months, she/he had been asking Staff 10 (Social Service Director) to schedule an appointment with an outside dental provider because she/he needed three tooth fragments removed from her/his upper gums and the lower teeth pulled so she/he could be fitted for dentures. On 8/5/25 at 2:05 PM, Staff 10 stated she was aware Resident 41 requested to see an outside dental provider and confirmed no appointment was scheduled. On 8/7/25 at 8:26 AM, Staff 4 (LPN-Care Manager) stated she was aware Resident 41 wanted to see an outside dental provider for at least the past few months. Staff 4 stated she was unaware if an appointment was scheduled. On 8/7/25 at 12:40 PM, Staff 2 (DNS) stated Resident 41's outside dental appointment was not yet scheduled and her expectation was the resident's dental appointment should have been scheduled in a more timely manner.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 kitchen food preparation areas were maintained in a clean and sanitary manner for 1 of 1 kitchen reviewed for sanitary kitchen practices. This placed residents at risk of illness and contaminated food. Finding include: Review of the US Food and Drug Administration 2022 Food Code indicated:The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence.The initial kitchen tour on 8/4/25 at 9:15 AM and follow-up kitchen visits on 8/6/25 at 9:02 AM and 8/7/25 at 10:01 AM revealed the following: -hundreds of small bugs with wings were observed on the windowsill above the food prep sink, in the food prep sink and on the steel counter where food was prepared. In addition, there were hundreds of small bugs caught in a bug trap sitting on the right side of the windowsill. Bugs were observed flying in the kitchen area near the clean food prep area and in the sanitary cleaning bucket used to wipe down food prep areas. -caulking along the windowsill above the food prep sink was missing and uncleanable. -there was a rancid odor emanating from under the food prep sink. On 8/4/25 at 9:23 AM and 8/7/25 at 10:01 AM, Staff 12 (Dietary Manager) stated they had been having trouble with small bugs with wings for a while. She confirmed there were hundreds of bugs on the windowsill above the food prep sink. Staff 12 stated in the afternoons, the bugs started swarming the window and windowsill which resulted in the window and windowsill being covered with bugs. Staff 12 stated the small bugs started migrating from the windowsill to the food prep sink and counters, so the kitchen staff had to move equipment and limit areas where they prepared food. Staff 12 stated the bugs flew around the kitchen and bit kitchen staff. Staff 12 stated the rancid smell under the food prep sink had been there for a while, the facility tried different things to identify and treat the smell, but the rancid odor persisted. Staff 12 stated the smell was worse on some days compared to others and smelled liked a dead animal.