STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38A031	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fernwood Supportive Living at Madrona Grove	13505 SE River Road Portland, OR 97222

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39632 Based on interview and record review it was determined the facility failed to ensure current copies of residents' advance directives were obtained and accessible in the health record for 1 of 7 sampled residents (#16) reviewed for medications and advance directives. This placed residents at risk for receiving medical treatments and life sustaining interventions against their wishes. Findings include: Resident 16 was admitted to the facility in ,d+[DATE] with diagnoses including Alzheimer's disease (a brain disease causing gradual decline in memory and cognitive function). Resident 16's Face Sheet revealed the section titled, Code Status was blank. Review of Resident 16's health record revealed no advance directive and no instructions regarding medical treatments and life-sustaining interventions the resident wanted in the event of a medical emergency. On [DATE] at 10:23 AM Staff 3 (RNCM) stated Resident 16 did not have an advance directive on file or instructions regarding medical treatments and life sustaining interventions which specified the resident's wishes in the event of a medical emergency. Staff 3 stated without specific instructions in the health record, Resident 16 was considered full code (a medical term meaning if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures would be provided to keep them alive. This process can include chest compressions (hard, aggressive pushing of the chest), intubation (insertion of a tube into the throat), and defibrillation (application of an electric current to the heart). On [DATE] at 10:38 AM Staff 4 (Director of Social Services) stated when residents admitted to the facility, she was responsible to interview the residents and family to find out if the resident had an existing advance directive, obtain the existing advance directive and ensure the documents were stored in the appropriate location in the residents' health records. Staff 4 stated if there was not an advance directive in the resident's health record, then that meant the resident did not have one. On [DATE] at 1:56 PM Staff 5 (LPN) stated in the event of a medical emergency, she referred to Resident 16's face sheet for instructions specific to medical interventions. Staff 5 stated if there were no instructions on the face sheet, she considered the resident a full code and she would administer CPR (cardiopulmonary resuscitation: chest compressions and defibrillation). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:26 AM Staff 2 (DNS) and Staff 3 were interviewed regarding the findings of this investigation. Staff 2 stated the residents' health records were the tools used by clinical staff to determine resident preferences and choices related to medical interventions and stated life-sustaining information was to be accessible in the section titled, code status. Staff 2 stated if the code status area was blank, the resident was considered to be a full code. On [DATE] at 11:33 AM Staff 3 located Resident 16's advance directive in a different electronic health record system which was not accessible to the facility's clinical staff. Staff 3 reviewed the advance directive; the advance directive indicated Resident 16 designated her/himself as do not resuscitate, and the document was dated ,d+[DATE]. Staff 2 verified Resident 16's advance directive was not obtained and accessible in the resident's current health record and in the event of a medical emergency, Resident 16's life-sustaining medical intervention preferences would not have been honored.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 39632 Based on interview and record review it was determined the facility failed to implement antibiotic stewardship practices for 1 of 5 sampled residents (#16) reviewed for medications. This placed residents at risk for adverse medication effects, inappropriate antibiotic use and potential for development of antibiotic resistance. Findings include: The CDC's 9/7/23 Antibiotic Prescribing and Use, website section titled, Core Elements of Antibiotic Stewardship for Nursing Homes recommended all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. The facility's 6/2018 Antibiotic Stewardship Policy & Procedure specified antibiotics were prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program, in compliance with National Guidelines and the facility assessed all data and requested needed laboratory tests, for example, UA (urinalysis: used to examine urine) and a C&S (culture and sensitivity: test to determine the appropriate antibiotic). Resident 16 was admitted to the facility in 5/2023 with diagnoses including irregular heart beat. A 4/9/24 Physician Order specified the following: - nitrofurantoin monohydrate (antibiotic) 100 mg two times a day for infection for one week. - UA with C&S. Review of Resident 16's health record revealed no UA with C&S was completed before, during or after completion of the antibiotic course. A 4/15/24 Physician Order specified the following: - nitrofurantoin monohydrate (antibiotic) 100 mg two times a day for infection for 14 administrations. Review of Resident 16's health record revealed no UA with C&S was completed before the 4/15/24 antibiotic order was initiated. On 4/17/24 at 2:01 PM Staff 5 (LPN) stated Resident 16's urinary tract infection symptoms continued and the provider extended the course of the antibiotic for an additional seven days. On 4/18/24 at 11:13 AM Staff 2 (DNS) and Staff 3 (RNCM) were notified of the findings of this investigation and reviewed Resident 16's health record. Staff 3 was unable to locate evidence the UA with C&S was completed. Staff 3 stated the importance of the UA with C&S was to ensure the appropriate antibiotic was prescribed. Staff 2 acknowledged the UA with C&S was not completed as ordered.