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	08/07/2025

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 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 interview and record review it was determined the facility failed to ensure to review the infection control policies annually and failed to transport clean laundry in a manner to prevent cross contamination for 1 of 1 facility. This placed residents at risk for ineffective infection control program and cross contamination of laundry. Findings include: 1. Review of the facility Policy and Procedure Manual revealed:-Influenza and Pneumococcal Immunizations policy was last reviewed on 1/2020. Information in the policy did not include the latest CDC guidelines on pneumococcal vaccines (Pneumococcal conjugate vaccines 15, 20, and 21). -Antibiotic Stewardship policy was last reviewed on 5/2024.-Infection Prevention and Control Program policy was last reviewed on 10/2023. On 8/5/25 at 9:34 AM Staff 2 (DNS) stated the infection control policies were not reviewed yearly and Staff 10 (Assistant Director of Health Services) might have additional information. On 8/7/25 at 10:51 AM Staff 10 stated the DNS was to review all the policies and update as needed. When the policies were reviewed the review date was updated on the policy. Staff 10 stated the facility had multiple people fill the DNS position in the last few years. 2. The facility's undated Laundry Safety Sheet specified staff were to use plastic coverings on carts when transporting clean laundry to prevent dust and contamination. On 8/6/25 at 3:18 PM Staff 5 (CNA) was observed to wheel a laundry rack containing hanging dress shirts, folded shirts and socks through the living room and dining room adjacent to the kitchen to room [ROOM NUMBER]. The rack was not covered and the clothing was exposed as she transported the clothing. Staff 5 stated this was the only cart staff used to deliver clean laundry and she was unaware of a covered laundry cart. On 8/6/25 at 3:33 PM Staff 4 (Laundry Manager) stated residents' laundry was often washed and dried in the laundry room on the main floor by the shared living room and occasionally in the basement laundry room. She stated staff only use the uncovered laundry racks to collect residents' clean laundry and delivered the clothing items to their rooms. On 8/6/25 at 5:00 PM Staff 2 (DNS) stated she was aware staff delivered residents' laundry to their rooms using the uncovered laundry racks. She acknowledged delivering clean laundry using an uncovered rack exposed clean laundry to dust and cross contamination. Staff 2 stated it was necessary to use covered racks to ensure clean laundry remained uncontaminated during the delivery process.

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

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	08/07/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review it was determined the facility failed to maintain a homelike environment for 1 of 1 facility and 4 of 4 sampled residents (#s 1, 3, 7, and 8) reviewed for environment. This placed residents at risk for an unhomelike environment. Findings include:1. On 8/6/25 at 8:11 AM the following observations were made of the facility handrails: -Near the corner where two rails meet by room [ROOM NUMBER] there was missing wood creating a rough area which was approximately one inch by one half inch.-Near the corner where two handrails meet across from room [ROOM NUMBER] there was missing wood creating a rough area which was approximately one inch by one half inch.-Across the hall from room [ROOM NUMBER] there was a deep one inch by one half inch gouge. -By room [ROOM NUMBER] there was missing wood creating a rough area which was approximately one inch by one half inch.-By room [ROOM NUMBER] near the corner where two handrails meet there was missing wood creating a rough area which was approximately one-half inch. -By room [ROOM NUMBER] there was missing wood creating a rough area missing wood which was approximately one and one inch long and one-half inch deep. On 8/6/25 at 10:22 AM Staff 16 (Maintenance Preventative Lead) stated he was not aware of the handrail gouges, and if he was not notified of the issue, he could not fix the damage. On 8/6/25 12:14 PM Staff 2 (DNS) stated she was not aware of concerns related to the facility handrails.2. Resident 1 was admitted to the facility in 11/2019 with a diagnosis of chronic lung disease.Resident 1's 6/27/25 Annual MDS revealed she/he was cognitively intact. Resident 1's 7/16/25 Care Conference Review Notes revealed her/his spouse wanted the resident's carpet replaced and the bathroom wall fixed and painted. The note indicated a work order was in progress. On 8/4/25 at 1:50 PM in the center of Resident 1's carpet was a soiled area which was approximately three feet in diameter. On 8/6/25 at 8:21 AM Staff 8 (CNA) stated Resident 1's carpet was cleaned in the past but the stain could not be removed, and would likely need to be replaced. Staff 8 stated the stain was from Resident 1's wheelchair because she/he was able to go outside and her/his wheelchair tires were dirty from the community outings. On 8/6/25 at 12:14 PM Staff 2 (DNS) stated on 7/16/25 Resident 1's spouse requested the carpet be replaced. In order for the carpet to be replaced Resident 1 would need to vacate her/his room for at least 24 hours. E-mails were sent to management but there were no concrete decisions made on how to facilitate the carpet replacement. Staff 2 acknowledged the bathroom wall could have been repaired but a work order was not submitted until 8/6/25. On 8/7/25 at 9:03 AM Resident 1 stated no one offered to replace the carpet and change rooms prior to 8/7/25. On 8/7/2025 10:51 AM Staff 10 (Assistant Director of Health Services) stated she was aware Resident 1's carpet needed to be replaced and the wall needed to be repaired. Staff 10 stated the facility staff may not have been aware of how to facilitate the process. 3. Resident 3 was admitted to the facility in 11/2017 with a diagnosis of dementia. Resident 3's 6/19/25 quarterly MDS revealed she/he was cognitively impaired. On 8/6/25 at 10:22 AM with Staff 16 (Maintenance Preventative Lead) nine gouges were observed on the wall behind Resident 3's head of the bed ranging from one inch in length to six inches in length. Three of nine gouges were deeper and were approximately one-half inch deep. Damage to the paint and drywall was also observed on the lower wall next to the bathroom sink which was approximately four inches long and one inch wide. Staff 16 indicated if he was not notified of the damage, he was not able to fix the issues. On 8/6/25 12:14 PM Staff 2 (DNS) stated she was not aware of concerns related to Resident 3's walls. 4. Resident 7 was admitted to the facility in 6/2016 with a diagnosis of Huntington's disease (genetic nerve disease causing motor and sensory deficits which worsen over time).On 8/6/25 at 12:55 PM Resident 1's carpet was observed to have a stained area which was approximately three feet in diameter.On 8/6/25 9:47 AM Staff 16 (Maintenance Preventative Lead) stated if a carpet was stained and the carpet tiles needed to be replaced, he was notified. He was not (continued on next page)

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	08/07/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified there were any residents in the facility who needed carpet tiles replaced, including Resident 7's carpet. On 8/6/25 at 12:14 PM Staff 2 (DNS) stated Resident 7's carpet was stained for at least six months. Resident 7 did not walk so it would be possible to replace the carpet tiles without needing to relocate her/him to another room. 5. Resident 8 was admitted to the facility in 5/2018 with a diagnosis of diabetes.Resident 8's 11/13/24 annual MDS revealed she/he was forgetful, but able to engage in conversation. On 8/4/25 at 10:59 AM Resident 8 was observed sitting in her/his recliner chair. Behind the recliner there were significant gouges in the wall behind the chair where the chair head rest corners hit the wall. On 8/6/25 at 10:22 AM Staff 16 (Maintenance Preventative Lead) verified the gouges and stated he was not aware of the gouges, and if he was not notified of the issue, he could not fix the concern. On 8/6/25 12:14 PM Staff 2 (DNS) stated she was not aware of concerns related to Resident 3's walls, staff informed her it occurred on 8/6/25.

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	08/07/2025

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 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 observation, interview and record review it was determined the facility failed to ensure a system was in place to resolve resident grievances including a lack of an identified Grievance Official and a lack of information available to residents on how to file a grievance for 1 of 1 facility reviewed for Resident Council. This placed residents at risk for unresolved grievances. Findings include:The facility's Resident Grievance Policy & Procedure, dated 1/2024, included the following:-A resident and/or her/his legal representative may voice a grievance to any staff in person, by telephone, email, or in writing.-Complete details of the grievance are documented so the grievance can be resolved within thirty (30) calendar days.-All information related to the resident's grievance would be held in strict confidence and not be disclosed to staff or contract providers, except when appropriate to process the grievance.The policy did not specify how long the facility was required to retain grievance forms.On 8/6/25 at 3:15 PM Staff 2 (DNS) stated the facility did not have a process for providing residents or their representatives grievance forms. Staff 2 was unaware of how the grievances were tracked, who the grievance official was, how the grievances were followed up on or the amount of time the facility kept the forms.On 8/7/25 at 10:07 AM Resident 5 and at 10:21 AM Resident 8 stated they attended Resident Council occasionally and they were unaware of how to file a grievance.On 8/7/25 at 11:37 AM Staff 7 (CNA) and Staff 8 (CNA) reported they were not aware of a grievance form, the formal process for submitting grievances, or the process resolving resident concerns.On 8/7/25 at 11:42 AM Staff 10 (Assistant Director of Health Services) stated residents, or their representatives typically verbalized concerns or sent emails when expressing a grievance. Staff 10 reported grievance documentation was kept in residents' charts and indicated she was unaware of who the designated staff member responsible for tracking and addressing grievances. On 8/7/25 at 3:18 PM Staff 1 (Administrator) acknowledged there was not a specific form used to document grievances and no formal process in place for collecting, reviewing, or tracking grievances to ensure their resolution. Staff 1 confirmed there was no process in place for maintaining grievance records for the required three years.

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	08/07/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review it was determined the facility failed to maintain records of consent for covid vaccines for 5 of 5 sampled residents (#s 5, 6, 7, 12, and 15) reviewed for immunizations. This placed residents at risk for uniformed decisions. Findings include: 1. Resident 5 was admitted to the facility in 1/2023 with a diagnosis of a fracture. Resident 5's 8/2024 Quarterly MDS revealed she/he was cognitively intact. Resident 5's 9/30/24 Covid -19 vaccination form revealed no education was provided prior to administration.On 8/6/25 at 5:05 PM Resident 5 stated she/he did not recall if staff provided education regarding the risk and benefits of the vaccine prior to administration. Resident 5 stated she/he wanted the vaccine and just remembered staff came around, she/he said yep, and did not remember signing any documents. On 8/5/25 at 10:51 AM Staff 2 (DNS) stated a local pharmacy had come to the facility to administer the flu vaccines. Staff 2 also stated the facility did not make any copies of the paperwork for the residents' clinical records, and the pharmacy was not able to provide copies of the consents.2. Resident 6 was admitted to the facility in 9/2024 with a diagnosis of cancer.Resident 6's 6/20/25 Quarterly MDS revealed she/he was cognitively intact. Resident 6's 4/30/25 Covid-19 vaccine form revealed she/he was provided education prior to administration. On 8/5/25 at 10:51 AM Staff 2 (DNS) stated a local pharmacy had come to the facility to administer the flu vaccines. Staff 2 also stated the facility did not make any copies of the paperwork for the residents' clinical records, and the pharmacy was not able to provide copies of the consents.On 8/6/25 at 3:52 PM Resident 6 stated she/he did not remember if the facility reviewed the risk or benefits of the vaccine or if she/he signed a consent.3. Resident 7 was admitted to the facility in 6/2016 with a diagnosis of Huntington's disease (genetic nerve disease causing motor and sensory deficits which worsen over time). Resident 7's 5/23/25 Quarterly MDS revealed she/he was moderately cognitively impaired. Resident 7's clinical record revealed she/he received a Covid-19 vaccine on 9/30/24 and education was not provided. Resident 7's clinical record did not reveal a Covid-19 signed consent form.On 8/5/25 at 10:51 AM Staff 2 (DNS) stated a local pharmacy had come to the facility to administer the flu vaccines. Staff 2 also stated the facility did not make any copies of the paperwork for the residents' clinical records, and the pharmacy was not able to provide copies of the consents.On 8/6/25 at 3:25 PM Resident 7 stated she/he did not remember if she/he signed anything for the vaccine, but thought she/he was provided the risk and benefits.4. Resident 12 was admitted to the facility in 12/2024 with a diagnosis of Parkinson's disease.Resident 12's 7/14/25 Quarterly MDS revealed she/he was cognitively impaired.Resident 12's Covid-19 vaccine form revealed she/he was provided education prior to vaccine administration. Resident 12's clinical record did not reveal a Covid-19 signed consent form.On 8/5/25 at 10:51 AM Staff 2 (DNS) stated a local pharmacy came to the facility to administer the Covid-19 vaccines. Staff 2 stated if the facility did not make copies of the paperwork for the resident's clinical records and the pharmacy was not able to provide copies for the resident's record.5. Resident 15 was admitted to the facility in 11/2024 with a diagnosis of diabetes. Resident 15's 4/15/25 Covid-19 vaccine form revealed she/he was provided education prior to administration. Resident 15's 6/5/25 Quarterly MDS revealed she/he was cognitively intact.On 8/5/25 at 10:51 AM Staff 2 (DNS) stated a local pharmacy had come to the facility to administer the flu vaccines. Staff 2 also stated the facility did not make any copies of the paperwork for the residents' clinical records, and the pharmacy was not able to provide copies of the consents.On 8/6/25 at 5:26 PM Resident 15 stated she/he remembered being administer the Covid -19 vaccine but did not recall the details of the paperwork or if she/he did any paperwork.

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	08/07/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review it was determined the facility failed to ensure psychotropic medications were not increased without indication and failed to perform a GDR (gradual dose reduction) for 1 of 5 sampled residents (#10) reviewed for unnecessary medications. This placed residents at risk for sedation. Findings include:Resident 10 was admitted to the facility in 3/2023 with a diagnosis Lewy body dementia (progressive decline in cognition with symptoms including hallucinations which can occur throughout the disease's progression.)Resident 10's 4/11/25 Annual MDS revealed she/he had Lewy body dementia with significant cognitive impairment, experienced hallucinations, and was administered antipsychotic and antidepressant medications. a. Resident 10's 5/2025 MAR revealed she/he was administered Seroquel (antipsychotic) 50 mg in the morning, 100 mg midday and 150 mg at bedtime. Progress Notes Revealed the following:-5/20/25 An order was received to discontinue Resident 10's AM dose of Seroquel. -5/21/25 and 5/22/23 Resident 10 did not exhibit behaviors.-5/23/25 Resident 10 started to hallucinate at 6:00 PM, refused medications, and was combative when the CNAs attempted to provide care. -5/25/25 through 6/5/25 Resident 10 did not have behaviors. -6/6/25 Resident 10 started to hallucinate at approximately 11:30 AM, behaviors escalated into shouting and screaming until approximately 2:15 PM. Later into the evening the resident continued to hallucinate, screaming and shouting and at approximately 7:30 PM fell asleep. -6/7/25 Resident 10 yelled and was combative during cares. Staff reapproached the resident, provided 1:1 interventions, music therapy and she/he eventually calmed down. It was noted Resident 10 yelled for approximately two hours in the afternoon, hallucinated and interventions attempted were not successful. Resident 10 stated Go away i [sic] will kill you. -6/9/25 a request to restart the AM dose of Seroquel due to a failed dose reduction. -6/10/25 An order was obtained to restart the Seroquel 50 mg AM dose. Resident 10's 6/2025 Documentation Survey Report (CNA documentation) revealed staff were to monitor behavior symptoms. From 6/10/25 to though 6/30/25 there were no behaviors documented. Resident 10's 6/2025 TAR revealed the nurses were to document behaviors. From 6/10/25 through 6/30/25 Resident 10 had agitation and aggression on 6/14/25 and 6/20/25.Resident 10's 7/2025 Documentation Survey Report revealed staff were to monitor behavior symptoms. From 7/1/25 through 7/8/25 there were no behaviors documented. Resident 10's 7/2025 TAR revealed the nurses were to document behaviors. From 7/1/25 through 7/8/25 there were no behaviors documented. Progress Notes revealed the following:-6/14/25 Resident 10 yelled out three times, was not able to be redirected and hallucinated. Resident 10 continued to hallucinate until approximately 4:00 PM, ate dinner and then went to sleep. -6/15/25 Resident 10 called out for short periods only lasting no more than 15 to 30 seconds. No additional behaviors noted. -6/16/25 Resident 10 was restless, staff assisted her/him to her/his room and soon she/he was sleeping. -6/17/25 through 6/19/25 Resident 10 did not have behaviors. -6/20/25 Resident 10 started to hallucinate at 4:30 PM, staff took her/him to her/his room and interventions offered were not effective. Resident 10 fell asleep at 7:00 PM-6/26/25 Resident 10's outburst and behaviors lessened with the restart of her/his medications. -6/27/25 through 7/7/25 no notes related to Resident 10's behaviors.-7/8/25 a new order was obtained for an increase to Resident 10's midday Seroquel dose. Resident 10's 7/2025 MAR revealed starting 7/9/25 she/he was to be administered Seroquel 50 mg in the morning, the Seroquel midday dose was to be increased to 150 mg (was 100 mg), and the Seroquel at bedtime dose remained at 150 mg. On 8/5/25 at 2:47 PM Staff 7 (CNA) stated at times Resident 10 became agitated when there was too much noise and stimulation. When there was too much stimulation Resident 10 hallucinated and yelled. At times she/he seemed scared, but other days she/he slept all day. On 8/6/25 at 9:15 AM Staff 8 (CNA) stated at times Resident 10 was up late and then the next day she/he slept more. If Resident 10 had behaviors the CNAs notified the nurse and the CNAs documented the behavior in the CNA documentation. On 8/6/25 at 5:44 PM Staff 9 (RN) stated (continued on next page)

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	08/07/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 10's behavior varied. Once they tried to decrease Resident 10's medication and her/his behaviors worsened. If Resident 10 exhibited behaviors the nurses were to document in the Progress Notes and TAR. On 8/6/25 at 4:12 PM Staff 2 stated staff were to document Resident 10's behaviors in the clinical record. Staff 2 acknowledged there were only two days of behaviors documented after Resident 10's Seroquel was restarted on 6/10/25 until it was increased on 7/9/25. Staff 2 stated Resident 10's physician increased the Seroquel on 7/9/25 when she informed the physician Resident 10 continued to have hallucinations. Staff 2 acknowledged Resident's 10 clinical record did not support the increase in dosage. b. Resident 10's 6/28/25 Order Summary Revealed she/he was to prescribed fluoxetine (antidepressant) with a start date of 5/13/2023.A 4/16/25 Quarterly Review of Psychotropic Medications revealed Resident 10 was on fluoxetine since 5/16/23 with no gradual dose reduction. A handwritten note indicated a need for the physician to provide a letter indicating this was the lowest effective dose. No information was found in Resident 10's clinical record to indicate this was the lowest effective dose or a failed gradual dose reduction was attempted and failed. On 8/6/25 at 4:12 PM Staff 2 (DNS) stated Resident 10 was on the same dose of fluoxetine since admission and a request was sent to Resident 10's physician to address the concern, but a response was not received. Staff 2 stated she did not request involvement from the medical director to step in to assist with obtaining the letter from Resident 10's physician.

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	08/07/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to monitor a resident for a change of condition for 1 of 1 sampled resident (#13) reviewed for change of condition. This placed residents at risk for delayed care. Findings include: Resident 13 was admitted to the facility in 5/2023 with a diagnosis of dementia. Resident 13's Progress Notes revealed the following:-6/27/25 Resident 13 called Staff 14 (RN) to the room and reported she/he thought she/he had pneumonia. Staff 14 assessed Resident 13 to have an unstoppable coughing fit, a runny nose, clear lungs, and Resident 13 was provided tea, honey, and PRN allergy medication. The note indicated Resident 13 would be monitored. Resident 13's Progress Notes did not reveal there were any additional assessments of Resident 13's respiratory status after 6/27/25.Resident 13's clinical record did not indicate her/his temperatures, cough, or oxygen saturation levels were monitored on 6/27/28, 6/28/25, or 6/29/25.On 8/5/25 at 1:24 PM Staff 15 (RN) stated if a resident had a change of condition staff made a note on the clinical dashboard which created an alert. The alert then notified staff to assess and document on a resident. Usually, staff documented on a resident for 72 hours after a change of condition. Staff 15 stated at times a resident was monitored on the TAR and not in progress notes.On 8/7/25 at 7:21 AM Staff 14 stated in 6/2025 some residents in the facility had colds. Staff 14 stated Resident 13 had a diagnosis of allergies, and she was not sure if the resident's cough was related to allergies or if she/he was ill so she thought it would be best to monitor Resident 13 for a few shifts to ensure the cough was just allergies. Staff 14 stated she notified the oncoming shift. On 8/7/25 at 9:31 AM Staff 2 (DNS) stated Resident 13 had a history of allergies. In 6/2025 residents in the facility had colds and Resident 13 should have been monitored for a change to condition to ensure her/his symptoms were related to allergies versus an illness.

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	08/07/2025

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 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. Based on observation, interview, and record review it was determined the facility failed to ensure residents were free from accidents for 2 of 5 sampled residents reviewed for accidents (#s 7 and 14). This placed residents at risk for adverse medication reactions. Findings include: 1. Resident 7 was admitted to the facility in 6/2016 with a diagnosis of Huntington's disease (genetic nerve disease causing motor and sensory deficits which worsen over time). Resident 7's 2/21/25 Annual MDS revealed she/he required extensive assistance with her/his ADLs and was expected to decline, was incontinent, and did not transfer. Resident 7's 8/2025 MAR revealed staff were to administer an antifungal powder two times a day. On 8/4/25 at 11:41 AM a medicine cup with a white powder was observed on the bathroom sink counter. On 8/4/25 at 1:16 PM Staff 13 (CNA) stated the powder in Resident 7's room was an antifungal powder, and she applied it to the resident's rash. On 8/6/25 at 8:04 AM Staff 3 (RN) stated on 8/4/25 she put the antifungal powder in the resident's room and the CNA staff were to page her when the resident was in bed to be applied. On 8/7/25 at 9:28 AM Staff 2 (DNS) stated staff should not leave medications in residents' bathrooms to ensure adverse medication reactions did not occur. 2. Resident 14 was admitted to the facility in 2/2023 with a diagnosis of heart disease. Resident 14's 3/27/25 Annual MDS revealed she/he required assistance with ADLs and incontinence care. Resident 14's 8/2025 MAR revealed staff were to administer an antifungal powder two times a day. On 8/4/25 at 1:18 PM a medicine cup with a white powder was observed on the bathroom sink. Staff 13 (CNA) stated it was an antifungal powder for Resident 14's rash and she assisted the resident to apply the powder. On 8/6/25 at 8:04 AM Staff 3 (RN) stated on 8/4/25 she put the antifungal powder in the resident's room and the CNA staff were to page her when the resident was in bed to be applied. On 8/7/25 at 9:28 AM Staff 2 (DNS) stated staff should not leave medications in residents' bathrooms to ensure adverse medication reactions did not occur.

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	08/07/2025

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview and record review it was determined the facility failed to ensure residents received trauma informed care for 1 of 1 sampled resident (#5) reviewed for behavioral-emotional care and abuse. This placed residents at risk for re-traumatization. Findings include:The facility's Trauma-Informed Care Policy & Procedure date 11/2019, indicated the following:-Each resident will have a preliminary screening for trauma upon admission.-The facility will account for residents' experiences, preferences, and cultural differences in order to mitigate triggers that may cause re-traumatization of the resident. Potential causes of re-traumatization by staff may include, but are not limited to:a. Being unaware of the resident's traumatic history.b. Failing to screen resident for trauma history prior to treatment planning.c. Challenging or discounting reports of traumatic events.d. Endorsing a confrontational approach in counseling.e. Labeling behaviors/feelings as pathological.f. Failing to provide adequate safety.g. Minimizing, discrediting or ignoring resident responses.Resident 5 was admitted to the facility in 1/2024 with diagnoses including alcohol dependance and PTSD (Post-Traumatic Stress Disorder).Resident 5's 8/1/25 Quarterly MDS revealed the resident was cognitively intact and able to make herself/himself understood and understood others without difficulty.On 8/5/25 at 1:37 PM and on 8/6/25 at 12:37 PM, Resident 5 was observed in her/his room in bed facing the door without the lights on. Resident 5 stated she/he suffered from PTSD as a result of childhood trauma. Resident 5 stated no one at the facility discussed the cause of her/his PTSD or potential triggers for re-traumatization.No evidence was found in Resident 5's clinical record to indicate an assessment of the resident's trauma was completed or a care plan was developed to address the resident's potential trauma triggers.On 8/5/25 at 3:17 PM, Staff 12 (CNA) stated she was unaware if Resident 5 had PTSD and indicated it was not listed on the resident's Kardex (reference for resident care needs).On 8/6/25 at 9:19 AM, Staff 3 (RN) stated she was aware Resident 5 had trauma from her/his past but unaware if the resident had any triggers or a diagnosis of PTSD.On 8/6/25 at 11:13 AM, Staff 11 (Social Worker) stated trauma screenings were not completed at the time of admission for residents and confirmed she did not develop a care plan related to Resident 5's history of trauma or potential triggers.On 8/6/25 at 3:15 PM, Staff 2 (DNS) acknowledged Resident 5's trauma and stated nothing was implemented related to Resident 5's trauma triggers.

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	08/07/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review it was determined the facility failed to ensure a pharmacy recommendation was acted upon timely for 1 of 5 sampled residents (#10) reviewed for unnecessary medications. This placed residents at risk for inaccurate diagnoses. Findings include:Resident 10 was admitted to the facility in 3/2025 with a diagnosis of dementia. A Medical Director Report Medication Regimen Review performed between 5/19/25 and 5/21/25 revealed Resident 10 was administered fluoxetine (antidepressant) with a indication for use NEUROCOGNITIVE DISORDER WITH LEWY BODIES [abnormal deposit of proteins in the brain which can lead to problems with thinking, movement, and behavior]. The review indicated it was not an appropriate diagnosis for the use of fluoxetine. A handwritten note on the form indicated on 6/9/25 a request was made to Resident 10's Geriatric Psychiatrist to address the concern.Resident 10's 8/2025 MAR revealed her/his fluoxetine indication for use was neurocognitive disorder with Lewy bodies. On 8/6/25 at 4:12 PM Staff 2 (DNS) stated she expected physicians to respond to the pharmacy recommendations within one to two weeks. Resident 10's physician did not respond to the request to change the diagnosis, and Staff 2 did not involve the medical director to intervene.

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	08/07/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review it was determined the facility failed follow antibiotic stewardship for 1 of 1 sampled resident (#13) reviewed for antibiotics. This placed residents at risk for drug resistant organisms. Findings include:Resident 1 was admitted to the facility in 11/2019 with a diagnosis of bladder disorder. A 6/27/25 Annual MDS revealed Resident 1 had urinary retention and staff assisted with the resident with intermittent catheterization (inserting a sterile catheter into the urethra [tube that allows urine to pass outside the body] to drain the bladder of urine). Resident 1's 10/27/24 UA Dipstick Only form revealed her/his only negative finding was a trace of leukocyte esterase (detects white blood cells which could indicate a UTI).Progress Notes revealed the following:-10/27/24 Resident 1 reported she/he did not feel well and was required to be catheterized multiple times. Resident 1's spouse requested a UA be collected, a urine specimen was obtained and sent to the laboratory. -10/28/24 A fax was received from the pharmacy with orders for cephalexin (antibiotic) to be administered for 14 days.Resident 1's 10/2024 and 11/2024 MARs revealed she/he was administered cephalexin (antibiotic) from 10/28/24 through 11/10/24.Resident 10's clinical record did not have her/his 10/27/24 UA or culture results and progress notes to indicate the facility communicated with the physician's office for the culture to ensure the antibiotic was indicated.Resident 1's 10/31/24 McGeer Criteria for Infection Surveillance Checklist revealed UTI criteria NOT met. On 8/7/25 at 12:26 PM Staff 2 stated she did the McGeer's Surveillance form, and it indicated Resident 1 did not meet the criteria for an UTI. Resident 1's physician ordered the antibiotics and the facility did not receive the culture to ensure the antibiotics were appropriate.

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	08/07/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review it was determined the facility failed to maintain records of consent for vaccinations for 2 of 5 sampled residents (#s 5 and 7). This placed residents at risk for uninformed decisions. Findings include: 1.Resident 5 was admitted to the facility in 1/2023 with a diagnosis of a fracture. Resident 5's clinical record revealed on 9/30/24 she/he received a flu vaccine and education was not provided. Resident 5's clinical record did not reveal a signed consent form.Resident 5's 8/2025 Quarterly MDS revealed she/he was cognitively intact. On 8/5/25 at 10:51 AM Staff 2 (DNS) stated a local pharmacy came to the facility to administer the flu vaccines. Staff 2 stated the facility did not make copies of the paperwork for the residents' clinical records and the pharmacy was not able to provide copies of the consents.On 8/6/25 at 5:05 PM Resident 5 stated she/he did not recall if staff provided education of the vaccine prior to administration. Resident 5 stated she/he wanted the vaccine and just remembered the staff came around, she/he said yep and did not remember signing any documents. 2. Resident 7 was admitted to the facility in 6/2016 with a diagnosis of Huntington's disease (genetic nerve disease causing motor and sensory deficits which worsen over time). Resident 7's 5/23/25 Quarterly MDS revealed she/he was moderately cognitively impaired. a. Resident 7's clinical Record revealed on 9/30/24 she/he received a flu vaccine and education was not provided. Resident 5's clinical record did not reveal a signed consent form.On 8/5/25 at 10:51 AM Staff 2 (DNS) stated a local pharmacy came to the facility to administer the flu vaccines. Staff 2 stated the facility did not make copies of the paperwork for the residents' clinical records and the pharmacy was not able to provide copies of the consents.On 8/6/25 at 3:25 PM Resident 7 stated she/he did not remember if she/he signed anything for the vaccine, but thought she/he was provided the risk and benefits form. b. Resident 7's clinical record revealed she/he received two pneumonia vaccines but was eligible to receive an additional vaccine. Resident 7's clinical record did not have documentation to indicate an additional pneumonia vaccine was offered. On 8/5/25 at 10:51 AM Staff 2 (DNS) stated the facility just ordered the pneumonia vaccine. Staff 2 stated she was not sure the reason Resident 7 was not offered the vaccine in prior years.