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	06/04/2026

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review it was determined the facility failed to have the Infection Preventionist attend the quality assessment and assurance (QAA) committee meetings for 3 of 3 months reviewed for QAA. This placed residents at risk for unidentified and unmet needs. Findings include: Documentation of QAA/QAPI meeting minutes were requested from 3/2026 through 5/2026 which revealed a qualified Infection Preventionist did not attend any of the QAA/QAPI meetings.On 6/4/26 at 3:32 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged a qualified Infection Preventionist did not attend the QAA/QAPI 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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review it was determined the facility failed to have a qualified and trained Infection Preventionist in place for 1 of 1 facility reviewed for infection prevention and control. This placed residents at risk for inadequate infection control. Findings include: A Staff List provided on 6/1/26 did not identify an Infection Preventionist.On 6/2/26 at 9:30 AM, Staff 1 (Administrator) stated Staff 12 (RNCM) was the facility's designated Infection Preventionist.Staff 12 was out of the facility and unable to be interviewed.A review of documents provided by Staff 1 (Administrator) revealed Staff 12 completed 11 of 24 modules of training from CDC Train's program and no indication the modules were completed and no evidence of a completed certification.Additional information regarding completion of the training and certification was requested from Staff 1 (Administrator) and no additional information was provided.On 6/4/26 at 12:43 PM, Staff 1 confirmed there was no documentation verifying Staff 12 completed the appropriate certification to serve as the designated qualified Infection Preventionist.

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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 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. Based on interview and record review it was determined the facility failed to have a process in place to ensure resident rights to execute an advance directive, obtain copies for the medical record and periodically follow up on preferences for 2 of 3 sampled residents (#s 1 and 14) reviewed for advance directives. Findings include: The facility's advance care planning and end of life policy and procedure manual dated 12/2025 included the following: - The Licensed Social Worker will determine or review the POLST and advance directive choices of each resident on admission, quarterly, and with each change of status.- If resident chooses not to execute an advance directive, the Licensed Social Worker will document accordingly.1. Resident 1 was admitted to facility in 1/2024 with a diagnosis of alcohol dependence. Resident 1's 1/30/26 Annual MDS revealed the resident was cognitively intact.A review of Resident 1's progress notes revealed advance directives were discussed on 5/29/24, 8/22/24, and 9/4/24 with Resident 1 and she/he declined each time.On 6/2/26 at 2:38 PM, Resident 1 stated she did not have an advance directive and the facility did not regularly discuss it with her/him.On 6/3/26 at 12:58 PM, Staff 4 (Social Worker) stated she only asked about advance directives at admission, but did not follow up periodically with residents who did not have one. Staff 4 stated she unaware if she was required to periodically offer or talk about advance directives with residents.On 6/4/26 at 9:15 AM, Staff 1 (Administrator) acknowledged advance directives were not being discussed with residents on a regular basis. Staff 1 stated he expected Staff 4 to discuss advance directives upon admission, during quarterly care conferences and as needed. 2. Resident 14 was admitted to facility in 11/20/24 with a diagnosis of type two diabetes. Resident 14's 3/5/26 Quarterly MDS revealed the resident was cognitively intact.A review of Resident 14's progress notes revealed the following:- On 11/27/24, Resident 14 stated she/he had an advance directive.- On 1/14/26, Resident 14 stated she/he had old copies of an advance directive, but wanted to fill out a new one. A review of Resident 14's clinical record revealed copies of Resident 14's advance directive were not obtained. On 6/3/26 at 12:58 PM, Staff 4 (Social Worker) stated she only asked about advance directives at admission and would request copies, but did not follow up periodically. Staff 4 acknowledged Resident 14 said she/he had an advance directive and confirmed she had not followed up.On 6/4/26 at 9:15 AM, Staff 1 (Administrator) acknowledged advance directives were not being discussed with residents on a regular basis. Staff 1 stated he expected Staff 4 (Social Worker) to discuss advance directives upon admission and during quarterly care conferences.

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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 act upon and implement pharmacy recommendations for 1 of 5 sampled residents (#12) reviewed for medications. This placed residents at risk for unnecessary medications. Findings include: The facility's 11/2025 Pharmacy Recommendations and Medication Regimen Review Policy & Procedure Manual specified pharmacy recommendations are reviewed within five business days, follow up actions and implementation dates should be documented, and the MAR should be updated. Resident 12 was admitted to the facility in 5/2023 with diagnoses including dementia with behavioral disturbances. Resident 12's 3/2026 Physician Orders included diclofenac arthritis pain external gel 1% (pain relief gel) topical, apply to knees topically in the morning for pain. Resident 12's 3/17/26 Pharmacist's Recommendation to Prescriber specified to update the 3/2026 diclofenac order to include the missing dosage in grams as follows: diclofenac arthritis pain external gel 1%, apply 4 grams to knees topically in the morning for pain. There was no evidence the Pharmacist Recommendation was forwarded to the provider and there was no evidence the Recommendation was acted upon. Resident 12's 3/2026, 4/2026, 5/2026 and 6/2026 TARs revealed the Pharmacist Recommendation was not acted upon and implemented until 6/2/26. On 6/3/26 at 12:30 PM Staff 2 (DNS) stated pharmacy reviews occurred monthly, and any recommendations should be followed through with the provider and promptly implemented by nursing staff. Staff 2 acknowledged Resident 12's 3/2026 Pharmacist Recommendations were not acted on by the provider and not implemented until 6/2/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview it was determined the facility failed to ensure staff wore Personal Protective Equipment for 1 of 1 sampled residents (#2) reviewed for Transmission Based Precautions. This placed resident at risk for infections. Findings include: Resident 2 was admitted to facility in 12/2024 with a diagnosis of parkinsonism (an umbrella term for a group of conditions that cause movement problems, such as tremors, slowness, stiffness, and balance issues).Resident 14's 3/5/26 Quarterly MDS revealed the resident was cognitively intact.On 6/1/26 at 10:46 AM, Resident 2's door was observed to have a contact precaution sign with a storage container of PPE outside the door. The signage did not include information regarding what to put on before entering the room and where to doff PPE prior to exiting the room. Instructions on the sequence of donning and doffing PPE were inside of the drawer of the PPE bin. On 6/1/26 at 10:46 AM, Staff 10 (LPN) stated Resident 2 was on contact precautions due to vomiting, loose stools and stomach cramps and everyone was required to don PPE prior to entering the resident's room.On 6/1/26 at 12:15 PM, Staff 10 (Housekeeper) was observed inside of Resident 2's room, approximately two feet from the resident without a gown or mask. Staff 10 was observed exiting the room, then entering the room to take out the trash inside of the resident's room. Staff 10 exited the room and entered again to put a liner in the trash can. On 6/1/26 at 12:19 PM, Staff 10 was observed exiting the resident's room without a gown or mask. Staff 10 stated she just completed cleaning the resident's toilet and bathroom. Staff 10 stated she did not know what the contact precautions sign meant on the resident's door, was unsure who to ask, and unaware of what to do when the sign was on the door.On 6/4/26 at 10:44 AM, Staff 5 (Environmental Services Manager) stated she expected housekeeping staff to refer and follow the signage for PPE when residents had precaution signs on their doors. On 6/4/26 at 11:50 AM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged Staff 10 did not don PPE prior to entering Resident 2's room. Staff 2 stated she expected all staff and visitors to don PPE prior to entering Resident 2's room.