STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36494 Based on observation, interview and record review it was determined the facility failed to ensure residents were treated with dignity for 1 of 1 sampled resident (#137) reviewed for dignity, 3 of 15 residents (#s 2, 15 and 39) reviewed for assisted dining. This placed residents at risk for lack of dignity. Findings include: 1. Random observations on 7/30/24 from 12:20 PM through 12:50 PM (30 minutes) revealed Staff 19 (CNA) was in the Willamette dining room and Residents 2, 15 and 39 were all seated at the same table for lunch. Staff 19 stood or walked around the table to assist each each of the residents with their lunch meal. On 7/30/24 at 1:13 PM Staff 19 stated the three residents in the Willamette dining room needed assistance and cueing when eating their meals. Staff 19 acknowledged she stood and should have been seated to assist Residents 2, 15 and 39 with their meals. On 8/1/24 at 4:30 PM Staff 2 (DNS) stated she expected all staff to sit with residents who required assistance with eating. Staff 2 stated Staff 19 spoke with her regarding the 7/30/24 dining incident and acknowledged she was supposed to be seated when assisting Residents 2, 15 and 39 with their meals. 34324 2. Resident 179 admitted to the facility in 2024 with diagnoses including neurogenic bladder. Resident 179's 7/25/24 Care Plan indicated the use of an indwelling catheter related to a neurogenic bladder. Observations made on 7/29/24 at 10:50 AM, 11:40 AM, 12:59 PM and 7/30/24 at 12:00 PM revealed Resident 179 laying in bed with her/his room door open. Resident 179's exposed catheter bag contained urine, had no privacy cover and was visible from the hallway. On 7/30/24 at 12:07 PM Staff 2 (DNS) stated residents with catheters were to have a privacy bag or a flap covering the catheter. Staff 2 acknowledged there was no privacy bag or flap covering Resident 179's catheter bag and the resident's catheter was visible from the hallway.

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
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494 Based on observation, interview and record review it was determine the facility failed to ensure a residents call light was within reach for 1 of 2 sampled residents (#25) reviewed for physical environment. This placed residents at risk for lack of ADL assistance. Findings include: Resident 25 was admitted to the facility in 11/2017 with diagnoses including dementia and depression. The Quarterly MDS dated [DATE], revealed Resident 25 had a BIMS score of 15, which indicated the resident was cognitively intact. On 7/29/24 at 1:07 PM Resident 25 stated she/he needed assistance to move her/himself in bed and was not sure where the call light was located. Observations on 7/29/24 from 1:08 PM through 3:09 PM revealed Resident 25's call light was on the left side of her/his bed, on the floor, out of reach. Staff entered Resident 25's room at 1:18 PM, repositioned her/him, and took the resident's lunch tray, but did not ensure her/his call light was within reach. On 7/29/24 at 3:09 PM Staff 16 (CNA) entered the room and acknowledged Resident 25's call light was on the floor and out of reach. Staff 16 stated Resident 25 did not get out of bed and needed her/his call light for assistance. Staff 16 stated staff were expected to ensure call lights were within reach at all times. On 8/1/24 at 4:30 PM Staff 2 (DNS) stated she expected all staff to ensure residents' call lights were not on the floor and were accessible to residents at all times. Staff 2 acknowledged Resident 25's call light was out of reach for an extended period of time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50927 Based on interview and record review it was determined the facility failed to provide information related to financial responsibilities for 1 of 3 sampled residents (#14) reviewed for Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN). This placed residents at risk for unforeseen financial responsibilities. Findings include: Resident 14 admitted to the facility in 4/2024 and received Medicare services from 4/26/24 through 6/28/24. Resident 14 received and signed the NOMNC (Notice of Medicare Non-Coverage) on 6/26/24. Although the resident remained in the facility, there was no evidence the resident received a SNFABN providing information on the resident's financial liability. On 7/31/24 at 4:16 PM Staff 5 (Social Service Director) acknowledged Resident 14 did not receive the SNFABN form and did not receive information about financial responsibilities after discharging from Medicare services while remaining in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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. 36494 Based on observation and interview it was determined the facility failed to ensure resident dining environments were homelike, and resident shower rooms were clean for 1 of 2 dining rooms and 5 of 5 shower rooms reviewed for environment. This placed residents at risk for lack of homelike environment and an unsanitary environment. Findings include: 1. Observations on 7/30/24 at 9:25 AM and 8/1/24 at 10:01 AM revealed five individual shower rooms for residents. All five shower rooms were observed to have a heater vent, a small heater unit on the wall, and a ceiling fan. All of them were covered in cobwebs and had dust particle build-up on the exterior and inside (approximately quarter-inch thick dust particles) for each of the three separate components (ceiling fan, heater vent and small heater). On 8/1/24 at 9:32 AM Staff 20 (Housekeeper) stated housekeepers were responsible for cleaning all five shower rooms, which included dusting the ceiling fans, vents and heaters. Staff 20 stated she was unable to clean the accumulated dust particles inside the heater, vent and ceiling fan and would refer the task to Staff 3 (Maintenance Director) to clean. On 8/01/24 12:14 PM Staff 3 acknowledged the thick dust particle buildup in all five shower rooms (including the ceiling fan, heater vent and small heater). Staff 3 indicated he did not normally clean the ceiling fans or heaters unless the motors stopped working. Staff 3 stated it never crossed his mind to clean the heater vents. Staff 3 stated all five showers would be cleaned and dusted. 50927 2. On 7/29/24 at 1:06 PM lunch was observed in the main dining room. Six of 12 residents were served food on trays and no food or drinks were removed from the trays. On 7/31/24 at 1:03 PM lunch was observed in the main dining room. Eleven of 12 residents were served food on trays at the table. On 7/31/24 at 2:10 PM Staff 8 (Dietary Manager) stated the facility's protocol was to serve meals on the trays they were delivered on. Staff 8 further stated, I started here as a cook right before Covid and we have always done it that way. On 7/31/24 at 2:30 PM Staff 8 stated he checked the protocol and acknowledged staff were not to serve meals on trays to residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34702 Based on interview and record review it was determined the facility failed to comprehensively assess a resident's needs related to nutrition for 2 of 3 sampled residents (#s 17 and 42) reviewed for nutrition. This placed residents at risk for unmet nutritional needs and weight loss. Findings include: 1. Resident 17 admitted to the facility in 5/2024 with diagnoses including diabetes, end stage renal disease, and dependence on renal dialysis. The 5/15/24 Admission MDS Nutritional Status CAA did not include Resident 17's history, current nutritional status, or plan of care. On 8/1/24 at 1:15 PM Staff 2 (DNS) acknowledged the 5/15/24 Admission MDS Nutrition CAA was not comprehensive and did not include Resident 17's history, current nutritional status, or plan of care. 50928 2. Resident 42 was admitted to the facility on [DATE] with the diagnoses including fracture of the right femur, malignant neoplasm of the lung and type 2 diabetes. Resident 42's Admission MDS dated [DATE], Section V: Care Area Assessment (CAA) Summary identified resident's Nutritional Status CAA triggered for further assessment. There was no documentation in the resident's medical record indicating the Nutritional Status CAA was completed or notes referring to where an assessment could be found. On 8/1/24 at approximately 3:00 PM Staff 2 (DNS) confirmed the nutritional status CAA was blank and Resident 42's nutritional needs were not assessed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494 Based on observation, interview and record review it was determined the facility failed to implement a mobility device for 1 of 2 sampled residents (#37) reviewed for positioning and mobility. This placed residents at risk for functional decline. Findings include: Resident 37 was admitted to the facility in 10/2021 with diagnoses including a stroke and dementia. The Quarterly MDS, dated [DATE], revealed Resident 37 had an upper extremity impairment and lower extremity impairment to one side of her/his body. A physician order dated 1/9/24 indicated Resident 37 was to have an InterDry (skin protector) cloth placed into her/his right hand daily. Random observations from 7/29/24 through 7/31/24 revealed Resident 37 was either up in her/his wheelchair or in bed with no skin protecting device in the right palm of her/his hand. On 7/31/24 at 2:20 PM Staff 12 (CNA) stated Resident 37 was alert but had confusion and limitations to her/his right arm and hand. Staff 12 stated an InterDry cloth was to be placed in the resident's right hand at all times due to her/his contracture. Staff 12 entered the room while the resident was in bed and acknowledged Resident 37 did not have anything in her/his right hand. On 8/1/24 at 9:06 AM Staff 11 (CNA) and at 4:18 PM Staff 10 (Agency LPN) stated Resident 37 required an InterDry cloth in her/his right hand daily, due to her/his contracture. Staff 11 and Staff 10 stated it helped reduced sweat and yeast buildup in the palm of the resident's right hand. On 8/1/24 at 4:18 PM Staff 2 (DNS), Staff 6 (LPN Resident Care Manager) and Staff 18 (LPN Resident Care Manager) stated staff were expected to implement the physician order regarding the InterDry cloth and ensure Resident 37 had the InterDry cloth in her/his right hand at all times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50928 Based on observation, interview, and record review the facility failed to evaluate the potential risk of choking related to altered swallowing ability for 1 of 3 sampled residents (#430) reviewed for nutrition. This placed residents at risk for choking. Findings include: Resident 430 was admitted to the facility on [DATE] with diagnoses including stroke and dysphagia (difficulty swallowing). A 7/24/24 Speech Therapy Assessment completed while the resident was in the hospital identified medications crusted in either thin liquids or puree. The Evaluation indicated swallow deficits including a delayed swallow response, moderately impaired ability to swallow, and a mild deficit in protecting the airway during swallow. These swallowing deficits increased the risk of aspiration. Admission orders dated 7/25/24 did not include information related to safe medication administration (or alternatively, did not indicated safe swallowing precautions related to medication administration). No evidence was found in the resident's clinical record to indicate the facility addressed the 7/24/24 recommendation for crushed medication. A 7/26/24 Speech Therapy Assessment did not include information related to Resident 430's safe consumption of medication. Resident 430's care plan for dysphagia dated 7/28/24 did not include information related to safe medication consumption. On 7/31/24 at 8:54 AM Resident 430 was observed sitting up-right in bed while receiving morning medication in tablet form. After swallowing medication, the resident began aggressively coughing. Staff assisted the resident with clearing his/her airway. On 7/31/24 at 12:04 PM and on 8/1/24 at 9:21 AM Staff 21 (CMA) and Staff 24 (CMA) stated Resident 430 was not flagged for swallow precautions around medication administration. On 7/31/24 at 4:09 PM Staff 23 (SPL) stated the hospital speech therapy recommendations should have been reviewed upon admission. Confirmed Resident 430 was not assessed after admission for the ability to safely swallow medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34702 Based on interview and record review it was determined the facility failed to ensure dialysis services were in place including transportation, monitoring and communication with the dialysis provider for 1 of 1 sampled resident (#17) reviewed for dialysis. This placed residents at increased risk for complications associated with dialysis treatment. Findings include: Resident 17 admitted to the facility in 5/2024 with diagnoses including diabetes, end stage renal disease, and dependence on renal dialysis. The 5/14/24 care plan indicated Resident 17 was to receive dialysis on Tuesdays, Thursdays and Saturdays. a. On 7/29/24 at 2:01 PM Resident 17 stated transportation failed to pick her/him up from the facility for a dialysis appointment recently and she/he missed dialysis. Resident 17 further stated she/he was fluid overloaded due to missing the appointment. Progress notes indicated the following: -7/20/24 7:08 PM the provider was notified that transportation did not show up to take Resident 17 to dialysis on the morning of 7/20/24. Transportation staff stated Resident 17 did not have a ride scheduled. Resident 17 was on alert to monitor for signs and symptoms of fluid overload due to the missed dialysis appointment until the next appointment on Tuesday (7/23/24). -7/20/24 10:14 PM per the provider the resident required very close monitoring, weights daily, and strict fluid restriction for three days until the next dialysis day. -7/22/24 5:09 AM resident was on alert due to missed dialysis appointment. Resident 17 had left leg pitting edema. Lung sounds were clear to auscultation, all vital signs were within normal limits. The 7/2024 MARs indicated Resident 17 did not have weights documented on 7/22/24. On 7/31/24 at 2:25 PM Witness 1 (Dialysis Administrator) and Witness 2 (Dialysis Nurse Manager) stated Resident 17 missed her/his dialysis appointment on 7/20/24. Witness 1 and Witness 2 stated Resident 17 had dialysis scheduled three times per week but recently started receiving one additional treatment per week per physician orders. On 8/1/24 at 1:15 PM Staff 2 (DNS) acknowledged transportation services failed to transport Resident 17 to a dialysis appointment and she/he missed the ordered dialysis on 7/20/24. Staff 2 stated the expectation was for facility staff to ensure transportation services were provided for Resident 17's dialysis appointments. Staff 2 acknowledged Resident 17 had weights ordered for alert charting starting on 7/21/24 and there was no weight documented for 7/22/24 and no indication the weight was completed as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The 7/2024 Dialysis Communication forms indicated the following dates when the facility did not include weight, blood pressure, or if there were concerns or symptoms the resident experienced prior to dialysis: -7/4/24 -7/9/24 -7/13/24 -7/18/24 -7/19/24 On 8/1/24 at 1:15 PM Staff 2 (DNS) acknowledged the dialysis communication forms were incomplete on the identified dates. c. On 7/31/24 at 11:34 AM the facility provided dialysis communication forms for Resident 17. There were no dialysis communication forms completed for the following dates: 7/2/24, 7/3/24, 7/6/24, 7/16/24, 7/23/24 and 7/25/24. On 7/31/24 at 2:25 PM Witness 1 (Dialysis Administrator) and Witness 2 (Dialysis Nurse Manager) stated Resident 17 dialysis dates included 7/2/24, 7/3/24, 7/6/24, 7/16/24, 7/23/24 and 7/25/24. No information was found in the clinical record to indicate communication with the dialysis provider on the identified dates. On 8/1/24 at 1:15 PM Staff 2 (DNS) acknowledged there were no dialysis communication forms completed for 7/2/24, 7/3/24, 7/6/24, 7/16/24, 7/23/24, 7/25/24 and acknowledged Resident 17 received dialysis on the identified dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 36494 Based on interview and record review the facility failed to ensure residents did not receive unnecessary steroid medication for 1 of 6 sampled residents (#15) reviewed for unnecessary medications. This placed residents at risk for adverse medication consequences. Findings include: Resident 37 was admitted to the facility in 10/2021 with diagnoses including stroke and dementia. A physician's order dated 7/9/24 revealed an order for prednisone (a steroid medication) at 40 mg. Staff were to administer one tablet (40 mg) by mouth daily for five days and then administer half a tablet (20 mg) by mouth daily for four days for gout (inflammatory arthritis). A Medication Error Report dated 7/22/24 revealed Staff 10 (Agency LPN) mistakenly administered 40 mg of prednisone on 7/16/24 instead of the prescribed 20 mg. Staff 9 (LPN) discovered the error on 7/17/24. Staff 9 notified the physician and followed the directive to monitor Resident 37 for any severe reactions while continuing to administer the prednisone per the physician's order. On 7/29/24 Witness 3 (Complainant) stated Resident 37 was given an extra dose of prednisone, but was unable to recall the specific date. Witness 3 stated staff notified her/him of the error, and believed the resident did not experience any adverse reactions due to the additional dose. On 8/1/24 at 11:03 AM Staff 10 stated Resident 37 was on prednisone and was being tapered off of the medication. Staff 10 stated the order lacked specific start and stop dates. Staff 10 acknowledged the error, and emphasized the importance of triple checking medications orders and adherence to the five rights (right patient, right drug, right time, right dose and right route). Staff 10 further stated Resident 37 did not suffer adverse effects from the error. On 8/1/24 at 1:24 PM Staff 9 stated she discovered the medication error on 7/17/24. Resident 37 received an incorrect dose of prednisone on 7/16/24 due to the removal of two prednisone pills from the medication card (bubble packet). Staff 9 stated the physician was notified, and the resident did not experience side effects from the extra dose of prednisone given. On 7/22/24, the facility addressed the Past Noncompliance by completing the following actions: 1. Conducted a thorough investigation of the incident. 2. Interviewed staff members involved in the incident. 3. Provided staff education on 7/22/24 about the five rights and the importance of triple checking physician orders. On 8/1/24 at 3:49 PM Staff 2 (DNS) stated she was notified of the medication error related to Resident 37's extra dose of prednisone administered on 7/16/24. Staff 2 confirmed Staff 10 received education on the five rights and the necessity of triple checking orders to ensure alignment with the MARs. Staff 2 stated Resident 37 did not experience adverse outcomes due to the excessive dose of prednisone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 34702 Based on interview and record review it was determined the facility failed to have a dialysis contract in place for 1 of 1 sampled resident (#17) reviewed for dialysis. This placed residents at risk for not receiving appropriate dialysis services. Findings include: Resident 17 admitted to the facility in 5/2024 with diagnoses including diabetes, end stage renal disease, and dependence on renal dialysis. The 5/14/24 Care Plan indicated Resident 17 received dialysis three times a week. On 8/1/24 at 1:15 PM Staff 2 (DNS) acknowledged Resident 17 received dialysis from an outside provider and the facility did not have a signed contract with Resident 17's dialysis provider.