| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385077 | A. Building<br>B. Wing | 01/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marquis Springfield | 1333 N. First Street<br>Springfield, OR 97477 |

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|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a homelike environment for 1 of 1 facility reviewed for environment. This placed residents at risk for not having a homelike environment. Findings include: 1. Resident 74 was admitted to facility in 2015 with a diagnosis of type 2 diabetes mellitus. Resident 74's Annual MDS Assessment completed in 10/2025 indicated a BIMS of 15 (cognitively intact).On [DATE] at 10:23 AM, several rooms on the north hall, including Resident 74's room, were observed to have linoleum floors that appeared stained and dirty. On [DATE] at 9:42 AM. Resident 74 stated the floor in his room looked pretty bad. She/he stated the facility needed to do a better job caring for the floor. 2. A walk-through of the facility conducted [DATE] at 10:00 AM revealed the following items: - Hallway carpets were excessively worn, stained or torn in 5 of 5 halls utilized by residents. There was a divot in the hallway outside rooms [ROOM NUMBERS] that created a tripping hazard. -Door and casings were significantly scratched, marred and stained for 44 of 55 resident rooms observed. - room [ROOM NUMBER] contained warped, bubbling carpet - 13 of 16 rooms in the north hall contained stained linoleum. - rooms [ROOM NUMBERS] had worn, marred or chipped paint. room [ROOM NUMBER] had an unrepaired hole in the wall. - room [ROOM NUMBER] contained chipped linoleum. - In a small activity room utilized by residents 1 of 3 hanging lights had burnt-out bulbs and 3 of 3 hanging lights were unclean and/or contained debris. - In the main dining room, the Formica countertop on the beverage counter had large areas where the subsurface showed through and a closet door next to one of the entrances that was stained or dirty. In the large entryway the transition piece was broken. On [DATE] at 11:57 PM, Resident 32 was observed self-propelling down the hall between room [ROOM NUMBER] and 53. Resident 32 stated the carpet needed cleaning because it looked like someone bled to death on the floor. During a walk-through of the facility conducted on [DATE] at 9:30 AM, Staff 6 (Plant Operations Manager) stated he was aware of the needed repairs. He stated he had no comprehensive plan for building maintenance. On [DATE] at 12:35 PM, Staff 1 (Administrator) stated she was aware there were significant building maintenance items that needed to be addressed. |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>Based on record review and interview the facility failed to provide residents with a risk benefit assessment for 1 of 1 resident (# 74) assessed for food. This place residents at risk for uninformed choices. Findings include:Resident 74 was admitted to the facility in 2015 with diagnoses including diverticulitis. On 12/29/25 at 10:15 AM Resident 1 stated she/he was lactose intolerant kept getting food items containing dairy products with her/his meals. Resident 74 stated she/he takes Lactaid (a medication to treat lactose intolerance) before each meal however, she/he still will experience loose stools from the dairy products. An entry in the clinical record dated 2/15/23 revealed the resident was lactose intolerant. Physician orders dated 9/2024 for revealed an order for Lactaid. On 1/3/26 at 10:50 AM, Staff 11 (CNA) stated she often reminded Resident 74 her/his loose stools were related to eating foods containing dairy, but the resident continued to eat the foods she/he preferred. On 1/3/26 at 11:06 AM, Staff 12 (CNA) stated Resident 74 frequently experiences loose stools when she/he consumes dairy products. Staff 12 stated Resident 74 continues to eat dairy products. On 1/5/26 at 9:12 AM, Staff 10 (RD) stated she was aware Resident 74 took Lactaid so she assumed she/he was aware of the consequences of eating lactose-containing foods. Staff 10 stated she had not done a dietary assessment of Resident 74. On 1/5/26 at 9:19 AM, Staff 5 (RNCM) stated Resident 74 experienced significant diarrhea from eating foods containing lactose. Staff 5 stated Resident 74 was noncompliant with her/his dietary recommendations, but Staff 5 had not completed a Declination of Treatment (a risk/benefit analysis) with Resident 74 related to lactose. On 1/5/26 at 1:00 PM, Staff 4 (DNS) stated staff should have completed a Declination of Treatment with Resident 74 related to her/his lactose intolerance. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on interview and record review it was determined the facility failed to ensure a resident's skin injury was investigated for 1 of 3 sampled residents (#77) reviewed for non-pressure skin injury. This placed residents at risk for worsening wounds. Findings include: Resident 77 was admitted to the facility in 12/2025 with a diagnosis of heart disease. An Abuse Investigations policy last revised on 10/15/20 revealed if an injury of unknown source was reported an investigation was to be completed. At a minimum staff were to review documents, medical records, interview staff who identified the incident, the resident and any staff who may have been in contact with the identified resident. Resident 77's 12/24/25 admission MDS revealed she/he was cognitively intact. Resident 77's 12/29/25 Progress Note revealed a CNA and nurse observed blood on Resident 77's bed sheets. Resident 77 was assessed to have hit her/his left great toe and Resident 1 reported she/he was not able to feel her/his feet and did not know what happened. On 12/29/25 at 11:27 AM Resident 77 stated her/his toe was bleeding, staff stated she/he bumped it on something but stated she/he did not hit her/his foot on anything. Resident 1's clinical record revealed there was no investigation related to the left great toe skin injury. On 1/2/26 at 12:00 PM Staff 7 (LPN) stated if a new skin issue was identified a skin event was to be initiated. On 1/2/26 at 10:57 AM Staff 2 (RN Consultant) indicated the Skin Event form and investigation was not started on 12/29/25. On 1/5/26 at 11:49 AM Staff 4 (DNS) stated if a new skin issue was identified staff were to initiate a Skin Event form, an investigation was completed to ensure care and services were provided related to the skin injury, and a root cause analysis was completed to prevent future injuries. Refer to F684 example (b) for additional information. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure residents were given bed hold information for 2 of 2 sampled residents (#s 2 and 31) reviewed for hospitalization. This placed residents at risk for lack of information and unexpected financial costs. Findings include: 1. The facility Bed Hold Policy with an unknown revision date indicated facility staff were to complete an Oregon Notice of Transfer or Discharge and Bed Hold form with each resident transfer and ensure the resident had the paperwork when they transferred out of the facility.<br><br>Resident 2 admitted to the facility in 10/2025 with diagnoses including an infection to the left leg and diabetes. An 10/12/25 admission MDS indicated Resident 2 was cognitively intact.<br><br>A review of Resident 2's medical record revealed she/he transferred to the hospital on [DATE]. No information was found in Resident 2's medical record to indicate a bed hold was explained, offered, or given to Resident 2 when she/he left the facility.<br><br>On 1/5/26 at 12:04 PM, Staff 16 (LPN) stated nursing staff were expected to fill out the Oregon Notice of Transfer or Discharge and Bed Hold form and send with residents when they were transferred to the hospital. She stated she was unaware if Resident 2 received an Oregon Notice of Transfer or Discharge and Bed Hold form when she/he transferred to the hospital.<br><br>On 1/5/26 at 1:50 PM, Staff 4 (DNS) stated the expectation for the Oregon Notice of Bed Hold and Transfer form was for the resident to have the form when they left the facility or soon thereafter. She acknowledged no documentation could be found regarding a bed hold being explained, offered, or given to Resident 2 when she/he transferred to the hospital.<br><br>2. Resident 31 was admitted to the facility in 11/2025 with diagnoses including heart failure and respiratory failure.<br><br>The 12/4/25 admission MDS revealed Resident 31's BIMS assessment score was 15 (cognitively intact).<br><br>A 12/17/25 Oregon Notice of Transfer or Discharge and Bed Hold form revealed Resident 31 was transferred to the hospital due to a change of condition. The form revealed the resident would inform family of her/his transfer to the hospital. The form included details about the bed hold policy but did not indicate if the information related to the bed hold policy was discussed with the resident.<br><br>On 12/29/25 at 4:22 PM, Resident 31 stated no bed hold information was discussed or paperwork provided to her/him related to the bed hold policy at the time of her/his 12/17/25 hospital transfer.<br><br>On 1/2/26 at 2:33 PM and 4:03 PM, Staff 10 (LPN) and Staff 13 (RN) stated nurses completed the nursing portion of the Oregon Notice of Transfer or Discharge and Bed Hold form. Staff 10 and Staff 13 did not know how residents were to obtain the information once the nursing information was completed.<br><br>On 1/2/26 at 4:22 PM, Staff 14 (Hospital Liaison) stated nursing staff were to provide a copy of the Oregon Notice of Transfer or Discharge and Bed Hold form to residents when they transferred out of<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the facility.<br><br>On 1/5/26 at 11:32 AM, Staff 1 (Administrator) expected staff to review the bed hold policy with residents at discharge or soon after discharge. Staff 1 acknowledged Resident 31's Oregon Notice of Transfer or Discharge and Bed Hold form was incomplete and was to include information when the bed hold information was discussed with the resident.<br><br>On 1/5/26 at 1:44 PM, Staff 4 (DNS) expected staff to provide a copy for the Oregon Notice of Transfer or Discharge and Bed Hold form to the resident or family at the time of discharge and acknowledged follow-up with Resident 31 did not occur once she/he returned from the hospital. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>Based on observation, interview and record review the facility failed to provide meaningful activities designed to meet the interests of the resident for 1 of 1 resident (# 14) reviewed for mood. This placed residents at risk for decreased quality of life. Findings include:Resident 14 was admitted to the facility in 8/2025 with diagnoses including cerebral infarction (stroke). On 12/29/25 at 10:49 AM, Resident 14 stated she/he liked to read prior to his stroke. During observations 12/29/25 through 12/31/25 Resident 14 was observed in awake and in her/his bed without engaging in any activity. A review of Resident 14's clinical record revealed the following, In the past, I enjoyed reading a lot. Further review of the resident's Progress Notes revealed a nursing note dated 8/27/25 with the following, The stroke took my vision, and I am unable to read .I used to be an avid reader. A review of the resident's Activities Care Plan revealed the resident had no activities related to books. On 1/3/26 at 10:50 AM Staff 11 (CNA) stated Resident 14 spent most of his time in her/his bed or listening to television. On 1/3/26 at 11:06 AM, Staff 12 (CNA) stated Resident 14 didn't talk much or ask for things and was often just lying in her/his bed looking out the window. Staff 12 stated Resident 14 often seemed bored and could be irritable. On 1/5/26 at 11:08 AM, Staff 17 (Activities Director) stated a resident who expressed an interest in reading should have been offered audio books and it should be noted in the resident's clinical record if they do not want an activity. On 1/6/26 at 12:35 PM, Staff 1 (Administrator) stated the facility had options for audio books for residents and Resident 14 should have been offered audio books. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interview and record review it was determined the facility failed to follow physician orders and implement non-pressure injury interventions for 1 of 3 sampled residents (#77) reviewed for edema. This placed residents at risk for fluid overload and worsening wounds. Findings include: Resident 77 was admitted to the facility in 12/2025 with a diagnosis of heart disease. a. Resident 77's 12/19/25 Orders Detail revealed staff were to obtain daily weights and notify her/his medical provider if she/he had more than a three-pound weight gain in 24 hours or a five-pound weight gain in one week. Resident 77's weight log revealed the following dates when she/he had more than a three-pound weight gain in 24 hours:-12/18/25 272 pounds-12/19/25 275.8 pounds-12/20/25 279.4 pounds Resident 77's clinical record did not have documentation to indicate her/his medical provider was notified of the three-pound weight gain on 12/19/25 and 12/20/25. On 1/2/26 at 1:44 PM Staff 5 (RNCM) verified Resident 77's medical provider was not notified on 12/19/25 or 12/20/25 per physician orders when she/he had a weight gain. On 1/5/26 at 11:29 AM Staff 4 (DNS) stated if a resident had an order to notify her/his medical provider staff were to use the online communication tool which was linked to a resident's progress notes. b. Resident 77's 12/29/25 Progress Note revealed a CNA and nurse observed blood on Resident 77's bed sheets. Resident 77 was assessed to have hit her/his left great toe and Resident 1 reported she/he was not able to feel her/his feet and did not know what happened. On 1/2/26 at 12:00 PM Staff 7 (LPN) stated if a new skin issue was identified a skin event was to be initiated, the resident was to be monitored, and treatment was to be initiated. On 1/2/2026 1:44 PM Staff 5 (RNCM) stated skin treatments and monitoring were not initiated on the 12/2025 TAR on 12/29/25. On 1/5/26 at Staff (DNS) stated if a new skin issue was identified. Staff were to initiate a Skin Event form, an investigation was completed to ensure care and services were provided related to the skin injury, and a root cause analysis was completed to prevent future injuries. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observations, interviews, and record review it was determined the facility failed to ensure medications were not left at a resident's bedside, residents were monitored after an aspiration event, and fall interventions were in place for 3 of 7 sampled residents (#s 5, 43 and 83) reviewed for accidents and nutrition. This placed residents at risk for accidental poisoning, aspiration, and at risk for injuries from falls. Findings include:<br><br>1.Resident 5 admitted to the facility in 11/2025 with diagnoses including weakness and scoliosis.<br><br>On 12/29/25 at 10:39 AM, Resident 5 stated she/he rolled out of bed several times since admission in 11/2025. Resident 5 was observed lying in bed and fall mats were observed rolled up in the corner of the room.<br><br>A 11/23/25 Progress Note revealed Resident 5 had fallen while trying to take her/himself to the bathroom and fall mats were placed as an intervention.<br><br>A review of Resident 5's care plan revealed a 11/25/25 care plan for fall mats at bedside.<br><br>Multiple observations made from 12/29/25 through 1/2/26 revealed Resident 5's fall mats were rolled in the corner of the room.<br><br>On 1/5/26 at 11:02 AM, Resident 5's room was observed with Staff 14 (RCM) and Staff 14 confirmed there were no fall mats at the bedside. Resident 5 stated the fall mats were not being used anymore. Staff 14 acknowledged Resident 5 was care planned for fall mats at the bedside and staff were expected to follow the care plan.<br><br>On 1/5/26 at 11:52 AM, Staff 4 (DNS) stated staff were expected to follow residents' care plans and Resident 5 should have had fall mats at the bedside per care plan.<br><br>An 11/2016 facility Alert Charting-Clinical Assessment indicated the nurse shall assess and document identified changes in condition of residents, as identified. The facility policy is to assure the adequate monitoring and appropriate interventions for all residents whenever a change of condition, or incident occurs. Alert charting is used to identify residents who require monitoring, assessment and documentation in the clinical record at least once a shift, or as determined by the RCM.<br><br>2. Resident 43 was admitted to the facility in 1/2024 with diagnoses including kidney failure and falls.<br><br>A Progress Note dated 12/25 indicated Resident 43 had a piece of meat caught in her/his throat. She/he was able to clear the meat with a cough, burp, and drinking fluids. Resident 43 stated she/he had recent issues with meat and harder vegetables getting caught in her/his throat. Resident 43 was agreeable to trying chopped meats and an extra side of gravy with all meals.<br><br>On 12/16/25 at 9:29 AM, Staff 13 (LPN) stated she wrote the Progress note related to Resident 43 having food stuck in her/his throat. She stated she placed the resident on alert, notified the RCM and reported to the next shift.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/29/25 at 10:31 AM, Resident 43 stated she/he recently had meat and vegetables caught in her/his throat. She/he stated staff had not spoken to her/him regarding the food stuck in her/his throat.<br><br>On 1/5/26 at 9:09 AM, Staff 20 (CNA) stated she remembered a while back Resident 43 stated her/his food was getting stuck in her/his throat, but Staff 20 had not notified the nurse.<br><br>On 1/5/26 at 9:11 AM, Staff 21(LPN) stated on 12/16/25 Resident 43 had an incident of food getting stuck in her/his throat. Staff 21 stated Resident 43 eats in her/his room and is not monitored. Staff 21 acknowledged Resident 43 should have been placed on alert so staff could monitor her/his eating and observe for aspiration. Staff 21 stated Resident 43 should have been placed on alert to keep an eye on how she/he performed on a new diet.<br><br>On 1/5/26 at 12:19 PM, Staff 4 (DNS) stated she was not aware of the incident with Resident 43. Staff 4 stated her expectation was to place Resident 43 on alert and monitor for aspiration, the physician called, RCMs notified, Registered Dietitian notified, and therapy notified to evaluate Resident 43's diet and risk of aspiration.<br><br>3. Resident 83 was admitted to the facility in 11/2025 with a diagnosis of a UTI.<br><br>Resident 83's 11/21/25 admission MDS revealed she/he was cognitively intact.<br><br>On 12/29/25 at 12:53 PM anti-fungal powder was observed on Resident 83s bedside table.<br><br>On 12/30/25 at 1:21 PM Staff (LPN) stated the powder was not to be at the bedside. Resident 83 stated she did not use the powder.<br><br>On 12/31/25 at 10:43 AM Staff 2 (RN Consultant) stated medications were not to be kept at the bedside without physician orders, an assessment of a resident's ability to administer the medication and a lock box to store the medication. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observations, interviews, and record review it was determined the facility failed to maintain healthy nutrition status for 3 of 7 sampled residents (#s 12, 13, and 96) reviewed for pressure ulcers, tube feeding, and nutrition. This placed residents at risk for impaired nutrition. Findings include: Resident 12 was admitted to the facility on [DATE] with diagnoses including diaphragmatic hernia without obstruction (a condition in which an abdominal organ moves through an opening in the diaphragm into the chest area) and esophageal obstruction (functional impairment of swallowing due to a blockage in the esophagus).<br><br>The 10/7/25 Hospital Discharge Summary orders indicated the facility dietitian was to manage Resident 12's tube feed. Staff were to administer Jevity 1.2 at a continuous rate of 30 (ml/hour), (advanced G-tube feeding formula) administered at 10 ml every 12 hours, advancing to a goal 55 ml/hour, for a total of 1,320 ml over 24 hours.<br><br>On 10/7/25 Resident 12 weighed 117.2 pounds.<br><br>The 10/7/25 nutrition care plan indicted Resident 12 was at risk for impaired nutrition, was monitored during Nutrition at Risk (NAR) meetings, had a G-tube (feeding tube that goes straight into the stomach), and was coded NPO (nothing by mouth). Staff were to refer to dietitian for evaluation and recommendations. Resident 12's goal was to maintain or increase weight.<br><br>A 10/7/25 enteral feed order indicated staff were to administer Jevity 1.2 55 ml per hour via G-tube, 660 ml every 12 hours, for a total of 1,320 ml per 24 hours starting at 7:00 PM.<br><br>Review of the 10/2025 MAR revealed staff administered the following:<br><br>On 10/7/25 at 7:00 PM, staff documented NA (not administered).<br><br>On 10/11/25 at 7:00 PM staff administered 548 ml.<br><br>On 10/12/25 at 8:00 AM staff administered 548 ml and at 7:00 PM staff administered 569 ml.<br><br>On 10/13/25 at 7:00 PM staff documented NA (not administered).<br><br>The resident missed approximately 1,961 kcal compared to the prescribed order for these dates and feedings.<br><br>A 10/7/25 enteral feed order indicated staff were to administer via G-tube 255 ml water via G-tube every 12 hours, total 510 ml every 24 hours, tube feed goal 55 ml per hour starting at 7:00 PM.<br><br>Review of the 10/2025 MAR revealed staff administered the following:<br><br>On 10/7/25 at 7:00 PM, staff documented NA.<br><br>On 10/8/25: 510 ml administered at 8:00 AM.<br><br>On 10/9/25: 510 ml administered at 8:00 AM.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/11/25: 191 ml administered at 7:00 PM.<br><br>On 10/12/25: 198 ml administered at 7:00 PM.<br><br>On 10/13/25: staff documented NA.<br><br>On 10/18/25: 210 ml administered at 8:00 AM and 201 ml administered at 7:00 PM.<br><br>On 10/19/25: 217 ml administered at 7:00 PM.<br><br>On 10/20/25: 152 ml administered at 7:00 PM.<br><br>On 10/21/25: 240 ml administered at 8:00 AM and 500 ml at 7:00 PM.<br><br>On 10/27/25: 170 ml administered at 8:00 AM and 0 ml at 7:00 PM.<br><br>On 10/28/25: 188 ml administered at 8:00 AM and 170 ml at 7:00 PM.<br><br>On 10/29/25: 91 ml administered at 8:00 AM.<br><br>The resident missed approximately 911 ml of prescribed water.<br><br>On 10/8/25 Resident 12 weighed 115.0 pounds.<br><br>The 10/8/25 Dietary admission Assessment indicated Resident 12 was not NPO and the resident did not have problems with swallowing or chewing. The assessment indicated the resident recently gained or lost weight. Resident 12 reported she/he lost a lot of weight but it did not include documentation of the resident's usual body weight or nutritional goals.<br><br>No documentation was found in the medical record to indicate the care plan included the resident's preferences and goals.<br><br>On 10/9/25 Resident 12 weighed 111.0 pounds.<br><br>On 10/10/25 Resident 12 weighed 105.8 pounds.<br><br>A 10/10/25 Nutrition Weight Note indicated Resident 12 had a 5.1 percent weight loss since admission and the dietitian was to review the resident's tube feed orders to determine if they needed adjustment. Resident 12 was to be reviewed during NAR.<br><br>A 10/10/25 physician order indicated Resident 12 was referred to palliative care for a consult due to severe protein malnutrition and G-tube status.<br><br>A 10/10/25 Nutrition Weight Note indicated the dietitian reviewed Resident 12's current tube feed orders and recommended increasing the resident's formula due to weight loss.<br><br>On 10/10/25 a dietitian referral indicated a request to change current Jevity 1.2 at 55 ml/hour over 12 hours to Jevity 1.5 ml/hour over 24 hours, with 175 ml free water flush every six hours to provide a total of 1,980 kcal, 84 grams of protein, and 2,050 ml. Meeting 100 percent of the estimated kcal<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | needs, protein needs, and fluid needs.<br><br>The 10/14/25 Dietitian Assessment indicated Resident 12 required tube feeding was seen for weight monitoring. Estimated nutritional needs indicated the resident needed 1695-1940 kcal per day. The current order provided 1584 kcal per day. Updated orders were requested on 10/10/25. On 10/22/25 Staff 20 (RN/RCM) reviewed and signed the Dietitian Assessment. Staff 20 indicated Resident 12's orders were updated on 10/17/25 and the Resident 12's care plan was reviewed and updated.<br><br>The 10/16/25 Weight Nutrition at Risk Assessment indicated Resident 12 had significant weight loss. The facility sent a recommendation to increase Resident 12's g-tube formula to the Gastroenterologist, however, they declined to address recommendations until resident was seen in December 2025. The assessment also noted that the dietitian needed to resend the 10/10/25 G-tube feeding orders with clarification. The assessment indicated current interventions are not appropriate.<br><br>No documentation was found in the resident's medical record to indicate the order was implemented.<br><br>On 10/17/25 Resident 12 weighed 104.2 pounds.<br><br>On 10/17/25 Staff 10 (RD) sent a second referral with recommendations to update Resident 12's current G-tube orders. The recommendation was to change from Jevity 1.2 at 55 ml/hour over 24 hours to Jevity 1.5 ml/hour over 24 hours with 75 ml free water flush every six hours providing a total of 1,980 kcal, 84 grams of protein, and a total of 1,515 ml. Meeting 100 percent of the estimated kcal needs, protein needs, and fluid needs.<br><br>A 10/22/25 external feeding order instructed staff to administer Jevity 1.5 via G-tube 55 ml per hour via continuous 24-hour G-tube feeding pump. Staff to document amount received per shift.<br><br>Review of the 10/2025 MAR revealed staff administered the following:<br><br>On 10/22/25: 440 ml AM shift.<br><br>On 10/23/25: 265 ml AM shift, 350 ml PM shift and 510 ml night shift.<br><br>On 10/24/25: 155 ml AM shift, 497 ml PM shift and night shift.<br><br>On 10/25/25: 345 ml AM shift, 300 ml PM shift and 460 ml night shift.<br><br>On 10/26/25: 359 ml AM shift, 460 ml PM shift and 440 ml night shift.<br><br>On 10/27/25: 440 ml AM shift,188 ml PM shift and night shift.<br><br>On 10/28/25: 540 AM shift, 365 ml PM shift and 440 ml night shift.<br><br>On 10/29/25: 620 ml AM shift, 580 ml PM shift and 544 ml night shift.<br><br>On 10/30/25: 300 ml AM shift.<br><br>The resident missed approximately 2,378 kcal compared to the physician order.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/24/25 Resident 12 weighed 106.4 pounds.<br><br>A 10/30/25 enteral feed order indicated staff were to administer Jevity 1.5 via G-tube 55 ml over 24 hours continuous via pump. Staff to document total amount received. Start on 10/30/25 at 3:00 PM and end on 10/31/25 at 2:37 PM.<br><br>The 10/2025 MAR revealed the following:<br><br>On 10/30/25 PM shift documented NA and night shift did not document total received.<br><br>On 10/31/25 Resident 12 weighed 104.6 pounds.<br><br>On 10/31/25 no documentation was provided to indicate total received.<br><br>The resident missed approximately 1,949 kcal compared to the physician order.<br><br>A 10/31/25 enteral feed order indicated staff were to administer Jevity 1.5 via G-tube 65 ml per hour from 1400- 1000 via pump every shift. Staff to document total received. End date 11/10/25.<br><br>No documentation was found on the 10/2025 and 11/2025 MAR to indicate the total received:<br><br>On 11/7/25 Resident 12 weighed 103.8 pounds.<br><br>A 11/7/25 Nutritional Weight Note indicated per RCM weight loss may be due to missed feeding. Staff to continue monitoring weekly Weight loss continued to be significant and increased by 1 precent.<br><br>A 11/10/25 enteral feed order indicated staff were to administer Jevity 1.5 via G-tube 65 ml per hour from 11:00 AM through 3:00 PM. Staff document total formula received. End date 12/24/25.<br><br>The 11/2025 MAR revealed staff documented the total formula received for the resident 16 out of 60 scheduled feeding opportunities.<br><br>The 12/2025 MAR revealed the following shift with 0 ml formula administered:<br><br>PM shift: 12/1/25, 12/3/25 through 12/9/25, 12/15/25, 12/18/25, 12/22/25 and 12/23/25.<br><br>A 11/13/25 Nutritional Weight Note indicated Resident 12's weight loss continued but was slowly decreasing. Will plan to continue the current plan of care unless RCM's has different insights on the tolerance of tube feed.<br><br>On 11/14/25 Resident 12 weighed 102.7 pounds.<br><br>On 11/21/25 Resident 12 weighed 103.4 pounds.<br><br>A 11/25/25 Nutritional Weight Note indicated the dietitian will request additional milliliters from pump due to continued weight loss.<br><br>On 11/28/25 Resident 12 weighed 103.6 pounds.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/5/25 Resident 12 weighed 106.2 pounds.<br><br>On 12/12/25 Resident 12 weighed 110.8 pounds.<br><br>A 12/22/25 Nutritional Weight Note indicated that, based on calculations, Resident 12 should be getting 1,957 ml of G-tube formula over 24 hours.<br><br>A 12/24/25 eternal feed order indicated staff were to disconnect the resident from tube feeding at 7:00 AM or when total of 1,200 cc Isosource 1.5 had been administered. Staff to document amount received.<br><br>Review of the 12/2025 MAR revealed staff administered the following:<br><br>On 12/25/25: 1164 ml administered.<br><br>On 12/28/25: 1051 ml administered.<br><br>On 12/29/25: 1051 ml administered.<br><br>On 12/30/25: 1180 ml administered.<br><br>The resident missed approximately 531 kcal compared to the physician order.<br><br>On 12/31/25 Resident 12 weighed 120.4 pounds.<br><br>On 12/29/25 at 11:56 AM, Resident 12 reported she/he underwent surgery several months prior and had a feeding tube in place. The resident stated she/he was NPO and was becoming increasingly hungry every day. The resident further reported she/he lost more than 40 pounds within the past year. Resident 12 stated she/he did not recall being assessed regarding her/his feeding tube or having discussions related to nutritional goals. The resident expressed a desire to gain weight and stated she/he would be comfortable weighing 120 pounds.<br><br>On 12/31/25 at 2:30 PM, Staff 15 (NP) stated she was aware of Resident 12's significant weight loss and severe protein malnutrition and would have expected the dietitian to follow up regarding nutritional needs. Staff 15 confirmed she would expect orders to be followed up within a couple of days.<br><br>On 12/30/25 at 3:03 PM, Staff 10 (RD) stated she initially submitted a recommendation to increase Resident 12's G-tube feeding on 10/10/25. The order was returned on 10/17/25 due to inaccurate calculations. Staff 10 resubmitted the recommendations on 10/17/25 but it was not approved until 10/22/25. Resident 12's new order was not implemented until 10/24/25. Staff 10 acknowledged the order was not followed in a timely manner. Staff 10 requested retraining on 12/22/25 however this training had not occurred. Staff 10 further stated Resident 12's nutritional goals did not include an ideal weight, interventions were not effective, and the facility failed to meet the resident's nutritional needs.<br><br>On 12/31/25 at 10:35 AM, Staff 13 (LPN) stated she was not aware of Resident 12's history of weight loss or of the resident's ideal weight. Staff 13 further stated she did not recall the last time she was provided education regarding tube feeds.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/5/26 at 9:38 AM, Staff 14 (RCM) stated Resident 12 was reviewed during weekly NAR meetings and she was aware of Resident 12's significant weight loss. Staff 14 acknowledged Resident 12's G-tube orders were not followed up on in a timely manner. Staff 14 further stated she was not aware of the dietitian's recommended retraining related to G-tube feeding.<br><br>On 1/5/26 at 10:13 AM, Staff 4 (DNS) acknowledged staff failed to meet the resident's nutritional goals related to monitoring, following dietary orders, and G-tube feeding practices.<br><br>2. Resident 13 was admitted to the facility in 11/2025 with diagnoses including diabetes.<br><br>A review of weights revealed the following:<br><br>11/21/25 233 lbs.<br><br>12/4/25 236.8 lbs.<br><br>12/9/25 220 lbs.<br><br>12/12/25 221.1 lbs.<br><br>12/18/25 222.6 lbs.<br><br>12/29/25 221.2 lbs.<br><br>On 1/5/26 at 8:49 AM, Staff 10 (RD) stated Resident 13 had a significant weight loss on 12/9/25. Staff 10 stated Resident 13's weight loss was identified on 12/18/25 and Resident 13 was assessed for weight loss on 12/29/25. Staff 10 stated it was beneficial for Resident 13 to lose weight, but the weight loss was too rapid. Staff 10 stated she recommended nutritionally enhanced meals but stated the RCM did not want any interventions. Staff 10 stated she makes recommendations, and the RCMs choose whether to follow those recommendations.<br><br>On 1/5/25 at 9:11 AM Staff 5 (RN RCM) stated Resident 13 had significant weight loss on 12/9/25. Staff 5 stated Resident 13's weight loss was identified on 12/24/25 and Resident 13 was assessed for weight loss on 12/29/25. Staff 5 stated there were no recommendations from the RD due to the weight loss. Staff 5 stated Resident 13's provider had not been notified of the weight loss. Staff 5 stated it was expected for weight loss to be identified, and the provider should be notified at the time of the weight loss. Staff 5 stated it was expected weight loss was to be assessed within the week of weight loss. Staff 5 acknowledged Resident 13's weight loss was not identified, assessed, and the provider was not notified in a timely manner.<br><br>On 1/5/25 at 12:02 PM, Staff 4 (DNS) stated weights were reviewed every morning during the clinical meeting. Staff 4 stated when a resident had significant weight loss it was expected the RD would follow up with the resident, recommendations be put in place, the care plan updated, and the provider notified within the week of the identified weight loss. Staff 4 acknowledged Resident 13's weight loss was not identified and assessed timely and acknowledged Resident 13's provider had not been notified of the weight loss.<br><br>3. Resident 96 was admitted to the facility in 12/2025 with diagnoses including acute kidney failure and protein-calorie malnutrition.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A 12/19/25 physician order indicated the diet for Resident 96 was to include 75 grams of protein.<br><br>A 12/26/25 Dietitian Assessment revealed Resident 96 received no supplements, the resident ate 60% of her/his meals and received 42 grams of protein daily based on Staff 12's (RD) calculations. Staff 12 recommended Resident 96 receive increased calories and protein to meet her/his nutritional requirements, and the recommendation would be discussed with Staff 5 (RNCM). The assessment was not complete and required additional information from Staff 5.<br><br>The 12/30/25 admission MDS revealed Resident 96's BIMS assessment score was 15 (cognitively intact) and she/he received dialysis (a treatment to filter waste products and excess fluid from the blood).<br><br>On 12/30/25 at 4:03 PM, Resident 96 stated she/he received dialysis three times weekly and did not want breakfast before she/he left.<br><br>On 1/5/26 at 10:50 AM and 12:50 PM, Staff 5 stated he was unaware Resident 96 required additional nutritional resources.<br><br>On 1/5/26 at 11:02 AM, Staff 12 stated she was to communicate the nutritional concerns of residents during morning meeting. Staff 12 stated she neglected to communicate concerns related to Resident 96's nutritional status until 12/29/25 and followed her communication with an email on 12/30/25 to Staff 5.<br><br>On 1/5/26 at 1:39 PM, Staff 4 (DNS) stated an improved system of communication was needed. Staff 4 expected assessments to be completed within seven days and acknowledged Resident 96's nutritional interventions were not implemented timely. |

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| F 0743<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a resident does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless unavoidable.<br><br>Based on observation, interview and record review the facility failed to ensure residents did not display increased anger, withdrawal or depressive behaviors for 1 of 1 resident (# 14) reviewed for mood. This placed residents at risk for unidentified depression. Findings include: Resident 14 was admitted to the facility in 8/2025 with diagnoses including cerebral infarction (stroke). Resident 14's MDS completed 9/2025 revealed a BIMS score of 15 (cognitively intact) and a PQH9 score of 00 (not depressed).A 10/14/25 progress note revealed the resident was tearful and asked about options for therapy since she/he was discharged from physical therapy due to lack of progress and indicated the resident expressed frustration about not being able to go home. The resident had been described as pleasant and cooperative in previous notes. A progress note dated 10/15/25 revealed the resident declined her/his shower despite multiple attempts by staff to offer a shower. Resident 14's progress notes did not reveal any previous declinations of care. A progress note dated 10/19/25 revealed the resident called her/his mother believing she/he was scheduled to discharge and would be able to go home. A second progress note dated 10/19/25 revealed the resident had been tearful and upset and spoke of going home during her/his shower and was alert charted for depression for 1 week. A progress note dated 10/22/25 revealed the resident declined multiple offers of a shower or a bed bath. A progress note date 10/28/25 revealed the resident continued to express sexualized feelings toward the female CNA. A progress note date 10/29/25 revealed the resident refused showers and became irritable with staff. The clinical record revealed no previous documentation of irritable behavior toward care providers by the resident. A progress note date 11/5/25 revealed the resident refused offers of a shower by multiple staff members. A progress note dated 11/11/25 revealed the resident continued to express sexualized feelings toward the female CNA. Progress notes dated 11/11/25 revealed the resident was agitated, restless and confused. A progress note dated 11/12/25 revealed the resident was irritable and declined to have her/his weight taken or to shower. On 11/17/25 progress notes revealed the resident remained fixated on the female CNA who had been removed from his care team due to previously documented behaviors. A progress note dated 11/26/25 revealed the resident was irritable and refused bowel care and multiple offers of showers. The resident was described as unmotivated and avoiding eye contact. A progress note dated 11/30/25 revealed the resident refused to get out of bed. A progress note dated 12/4/25 revealed the resident refused her/his independent exercise therapy despite multiple offers. A progress note dated 12/17/25 revealed the resident was tearful during a provider visit related to wanting to gain strength. On 12/29/2025 at 10:49 AM, Resident 14 stated she/he felt depressed and suicidal and wanted to go home. Resident 14 stated she/he had not spoken to staff about feeling depressed or suicidal. Resident 14 presented with a flat affect and appeared uninterested in answering questions. On 1/3/26 at 10:50 AM, Staff 11 (CNA) described Resident 14 as not being very expressive and she/he needed to be checked on frequently as she/he would not ask for care. On 1/3/26 at 11:04 AM, Staff 12 (CNA) described Resident 14 as seeming to struggle with depression and sometimes tearful. On 1/5/26 at 9:28 AM, Staff 14 (RNCM) stated there was no indication in Resident 14's clinical record she/he had been assessed for depression or offered mental health therapy. On 1/5/26 at 9:37 AM, Staff 3 (Social Services Assistant) stated he had discussed mental health therapy with Resident 14 and the resident had declined. Staff 3 stated he had not requested the resident be evaluated by a practitioner for depression.On 1/5/25 at 1:00 PM, Staff 4 (DNS) stated she would want a practitioner to assess a resident if there were cumulative behaviors noticed by staff such as declining cares and changes in behavior or mood. Staff 4 stated declinations of assessment or treatment by residents should be documented in the resident's clinical record. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on interview and record review it was determined the facility failed to follow medication parameters for 1 of 5 sampled residents (#5) reviewed for medications. This placed residents at risk for side effects to medications. Findings include:Resident 5 was admitted to the facility in 11/2025 with diagnoses including hypertension (elevated blood pressure).A review of Physician Orders revealed a 12/12/25 order for Aldactone 12.5 mg twice a day (a medication to help remove extra fluid from the body) for fluid retention hold for systolic blood pressure (top number) less then 115 or hold for diastolic blood pressure less than 70 (bottom number).A review of Resident 5's 12/2025 MAR revealed Aldactone was documented as given with a diastolic blood pressure less than 70:12/19/25 at 1:00 PM 124/6212/20/25 at 1:00 PM 122/6012/21/25 at 7:00 AM 128/6812/24/25 at 7:00 AM 128/6812/24/25 at 1:00 PM 132/6812/25/25 at 7:00 AM 130/6012/26/25 at 1:00 PM 128/6012/28/25 at 1:00 PM 128/6012/31/25 at 7:00 AM 126/6612/31/25 at 1:00 PM 124/66 A review of Resident 5's 1/2026 MAR revealed Aldactone was documented as given with a diastolic blood pressure less than 70:1/1/26 at 7:00 AM 126/661/1/26 at 1:00 PM 120/641/2/26 at 7:00 AM 132/68On 1/2/26 at 9:23 AM, Staff 18 (CMA) stated Resident 5's Aldactone order indicated the medication was to be held when the diastolic blood pressure was less than 70. Staff 18 stated she administered Resident 5 the Aldactone on 12/31/25 at the 7:00 AM and 1:00 PM doses, on 1/1/26 at the 7:00 AM and 1:00 PM doses, and on 1/2/26 at the 7:00 AM dose. Staff 18 stated the Aldactone should have been held on the above dates due to the diastolic blood pressure less than 70. On 1/2/26 at 9:37 AM, Staff 2 (Regional Nurse Consultant) stated Resident 5's Aldactone order indicated the medication was to be held when Resident 5's blood pressure was less than 70. Staff 2 stated on the above dates and times, Resident 5's Aldactone should have been held per orders.On 1/2/25 at 12:15 PM, Staff 7 (LPN) stated Resident 5's order for Aldactone indicated the medication was to be held when Resident 5's blood pressure was less than 70. Staff 7 stated she administered Resident 5 on 12/25/25 at 7:00 AM and on 12/26/25 at 1:00 PM. Staff 7 stated the Aldactone should have been held on the above dates due to the diastolic blood pressure less than 70.On 1/5/26 at 7:49 AM, Staff 19 (CMA) stated she gave Resident 5 her/his medications on 12/20/25 and 12/21/25. Staff 19 stated if the documentation indicated the medication was administered then she administered the medication.On 1/5/26 at 11:52 AM, Staff 4 (DNS) stated it was expected staff follow orders and hold medications when the order indicated the medication be held. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review it was determined the facility failed to ensure an insulin open date was documented for 1 of 1 sampled resident (#17) observed to receive insulin during medication administration observation. This placed residents at risk for ineffective medication regimen. Findings include: Resident 17 was admitted to the facility in 9/2025 with a diagnosis of diabetes. Resident 17's 12/31/25 Active Orders included staff were to administer Lispro (fast acting insulin) with meals. On 12/31/25 at 7:41 AM Staff 8 (LPN) was observed to prepare Insulin Lispro for Resident 17. The Lispro insulin did not have an open date, and Staff 8 stated all insulin was to be dated when first opened. On 12/31/25 at 8:41 AM Staff 9 (LPN Resident Care Manager) stated insulin should be dated when opened. Staff stated the 12/2025 pharmacy receipt binder did not have a receipt for Resident 17's Lispro insulin and she was not able to determine when the Lispro was potentially first used. On 12/31/25 9:00 AM Witness 1 (Pharmacy Technician) stated the Lispro insulin was sent to the facility on [DATE]. On 12/31/25 at 10:42 AM and 12:05 PM Staff 2 (RN Consultant) stated all insulin was to be dated when opened. Staff 2 stated Lispro was good for 28 days after it was opened and at room temperature. |

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| Marquis Springfield | 1333 N. First Street<br>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 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on interview and record review it was determined the facility failed to ensure the influenza vaccine was offered to residents for 1 of 5 (#13) sampled residents reviewed for vaccinations. This placed residents at risk for influenza infection. Findings include: The facility Vaccination of Residents policy with a 5/2021 revision date indicated all residents were to be offered vaccinations that helped in preventing disease and all vaccination information was to be recorded in the resident's medical record. Resident 13 was admitted to the facility in 11/2025 with diagnoses including diabetes and urinary tract infection. A 11/27/25 admission MDS indicated Resident 13 was cognitively intact.During a review of Resident 13's medical record no information was found to indicate the influenza (flu) vaccine was offered for the 2025 flu season (October 2025 through May 2026). On 1/5/26 at 1:50 PM, Staff 4 (DNS) stated the expectation for resident flu vaccinations was for all residents to be offered the flu vaccine each flu season. She acknowledged Resident 13 was not offered the influenza vaccine for the 2025 flu season. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385077 | A. Building<br>B. Wing | 01/05/2026 |

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|---|---|
| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>Based on observation, interview, and record review it was determined the facility failed to ensure residents had an accessible bathroom call light for 2 of 3 sampled residents (#s 38 and 83) reviewed for accidents. This placed residents at risk for the inability to call for assistance. Findings include: 1. Resident 38 was admitted to the facility in 11/2024 with a diagnosis of dementia. On 12/29/25 at 12:42 PM Resident 38's bathroom was observed without a call light cord to access if she/her fell to the ground. On 1/2/26 at 10:32 AM Staff 6 (Maintenance) stated if a resident room did not have a call light cord the staff were to notify him, and he would provide a cord. Staff 6 stated he was not notified Resident 38 did not have a bathroom call light cord. On 1/5/26 at 10:28 AM Staff 1 (Administrator) stated she and Staff 4 (DNS) did audits to ensure residents' bathrooms had call light cords. Staff 1 stated the staff were to notify maintenance in person or via the facility online communication system if a resident needed a new call light cord. 2. Resident 83 was admitted to the facility in 11/2024 with a diagnosis of UTI. Resident 83's 11/23/25 admission MDS revealed she/he was cognitively intact. On 12/29/25 at 12:42 PM Resident 83's bathroom was observed without a call light cord to access if she/he fell to the ground. On 1/2/26 at 10:32 AM Staff 6 (Maintenance) stated if a resident room did not have a call light cord the staff were to notify him, and he would provide a cord. Staff 6 stated he was not notified Resident 38 did not have a bathroom call light cord. On 1/5/26 at 10:28 AM Staff 1 (Administrator) stated she and Staff 4 (DNS) did audits to ensure residents' bathrooms had call light cords. Staff 1 stated the staff were to notify maintenance in person or via the facility online communication system if a resident needed a new call light cord. |