

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Marquis Plum Ridge Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Bryant Williams Dr. Klamath Falls, OR 97601	
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interview and record review it was determined the facility failed to assess the use of a physical restraints for 3 of 4 sampled residents (#s 1, 3, and 4) reviewed for elopement. This placed residents at risk for potential abuse or neglect. Findings include: A 6/2024 revised Use of Restraints policy identified wander guards as a physical restraint. An informed consent and pre-restraining assessment was to be completed prior to use of the restraint. Restraints were only to be used if a resident had a specific medical condition that could not be addressed by another less restrictive intervention. If the resident could not remove a device in the same manner in which the staff applied it, that device was considered a restraint. 1. Resident 1 was admitted to the facility in 3/2025 with diagnoses including disorientation and peripheral vascular disease (narrow arteries). A 3/31/25 Elopement Risk Assessment identified Resident 1 was not at risk for elopement. A 3/31/25 Progress Note indicated Resident 1's wander guard (device that alarms staff and locks a door when a resident was near an exit) was in place. The 4/6/25 admission MDS indicated Resident 1 had cognitive deficits, her/his wander guard was used daily, and Witness 1 (Power of Attorney) assisted Resident 1 with decisions regarding care and housing. An 4/16/25 revised care plan indicated Resident 1's wander guard was located on her/his left ankle and behavior interventions included one on one reassurance, provide food, redirect, and provide privacy. No behaviors related to exit seeking tendencies were identified. A review of Resident 1's clinical record revealed no assessment or consent for the use of the resident's physical restraint. A 6/29/25 Nursing Note indicated Resident 1 was pacing the hallways with a suitcase in her/his hand and wanted to leave the facility. A 7/4/25 Nursing Note revealed Staff 4 (LPN) found Resident 1's wander guard strap, wander guard, and a plastic knife on the resident's vanity in her/his room. On 10/23/25 at 9:49 AM, Staff 13 (CNA) stated Resident 1 had a wander guard due to her/his exit seeking behaviors when she/he first admitted to the facility. On 10/23/25 at 11:19 AM, Witness 1 stated the facility never spoke to Resident 1 about her/his (continued on next page)		

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wander guard and the resident felt like a prisoner in the facility. On 10/23/25 at 3:21 PM, Staff 3 (RCM) stated a wander guard was placed on Resident 1 because the resident made a statement, she/he wanted to leave the facility, and it was unsafe after her/his surgery. Staff 3 stated she did not believe consents by residents or family members were required for the use of wander guards and acknowledged an updated assessment for the use of Resident 1's wander guard was lacking. On 10/24/25 at 9:41 AM, Staff 6 (LPN) stated she was aware paperwork was needed prior to the use of a wander guard for a resident but was unsure of the process. On 10/24/25 at 10:17 AM, Staff 2 (DNS) acknowledged there was no consent or assessment for Resident 1's wander guard and Staff 2 expected the facility to follow their own policy. 2. Resident 3 admitted to the facility in 5/2025 with diagnoses including vascular dementia. Resident 3's 6/2025 comprehensive care plan revealed she/he had cognitive impairment causing her/him to exit seek. The care plan indicated interventions of redirection and to wear the wander guard. An 10/24/25 medical record review revealed Resident 3 did not have an assessment for the use of a wander guard or consent on file. On 10/24/25 at 9:41 AM, Staff 6 (LPN) stated she was aware paperwork was needed prior to the use of a wander guard for a resident but was unsure of the process. On 10/24/25 at 10:17 AM, Staff 2 (DNS) acknowledged there was no consent or assessment for Resident 3's wander guard and Staff 2 expected the facility to follow their own policy. 3. Resident 4 admitted to the facility in 12/2024 with diagnose including right femur fracture. The 12/26/24 Annual MDS revealed Resident 4's cognition was severely impaired. Resident 4's 12/2024 comprehensive care plan revealed she/he experienced hallucinations and delusions that caused her/him to exit seek. Care plan interventions included wearing wander guard. An 10/24/25 medical record review revealed Resident 4 did not have an assessment for the use of a wander guard or consent on file. On 10/24/25 at 9:41 AM, Staff 6 (LPN) stated she was aware paperwork was needed prior to the use of a wander guard for a resident but was unsure of the process. On 10/24/25 at 10:17 AM, Staff 2 (DNS) acknowledged there was no consent or assessment for Resident 4's wander guard and Staff 2 expected the facility to follow their own policy.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review it was determined the facility failed to ensure proper interventions were in place to ensure a resident remained free from accident hazards for 1 of 5 sampled residents (#1) reviewed for accidents. This placed residents at risk for accidents. Findings include: 1. Resident 1 was admitted to the facility in 3/2025 with diagnoses including disorientation, peripheral vascular disease (narrow arteries), and diabetes. A 3/31/25 Elopement Risk Assessment identified Resident 1 was not at risk for elopement. A 3/31/25 Progress note indicated Resident 1's wander guard (device that alarms staff and locks a door when a resident was near an exit) was in place. The 4/6/25 admission MDS Psychotropic CAA indicated Resident 1 had cognitive deficits, living alone was not safe, and Witness 2 (Power of Attorney) was used to assist Resident 1 with decisions about her/his health and housing needs. An 4/15/25 Utilization Review/Discharge Planning noted Resident 1 had a SLUMS (screening tool for early signs of dementia) score of nine out of 30 which indicated dementia. An 4/16/25 revised care plan indicated Resident 1's wander guard was located on her/his left ankle and behavior interventions included one on one reassurance, provide food, redirect, and provide privacy. No behaviors related to exit seeking tendencies were identified. An 4/18/25 SLUMS Examination indicated a score of 15 out of 30 indicating dementia. A 6/29/25 Nursing Note indicated Resident 1 was pacing the hallways with a suitcase in her/his hand and wanted to leave the facility. On 7/4/25, Nursing Notes revealed the following: -At 4:24 AM, Resident 1 was provided Tylenol (pain medication) and spoke about wanting to leave the facility. Resident 1 was encouraged not to remain at the facility so wound care could be provided. -At 5:35 AM, Resident 1 was observed by Staff 4 walking with her/his cane and pulling a wheeled suitcase approximately one mile from the facility while Staff 4 drove to work. Resident 1 refused to return to the facility and continued to walk towards an open field. Staff 4 called the facility to notify them. -At 6:13 AM, Staff 4 contacted police and they transported the resident via ambulance to the hospital. -At 6:40 AM, Staff 4 found Resident 1's wander guard strap, wander guard, and a plastic knife on the resident's vanity in her/his room. On 10/21/25 at 4:38 PM, Staff 1 (Administrator) stated no investigation into Resident 1's disappearance on 7/4/25 was conducted because the resident did not elope. On 10/22/25 at 2:46 AM, Staff 11 (Social Services Director) stated information was provided about vascular dementia and memory care facilities to Witness 1 due to concerns for Resident 1. Staff 11 stated nursing staff and Staff 2 (DNS) were to be notified and work together to mitigate concerns of Resident 1's increased behavior. On 10/22/25 at 12:24 PM, Staff 4 stated the week before 7/4/25 Resident 1 had increased agitation and her/his dementia was like a see saw. Staff 4 stated he was concerned for Resident 1's safety when he observed the resident outside of the facility on 7/4/25 and the facility was unaware the resident was not in the facility until they were contacted the same day. On 10/22/25 at 3:26 PM, Staff 12 (LPN) stated he became aware Resident 1 left the building on 7/4/25 with no wander guard while Staff 12 assisted another resident. On 10/23/25 at 9:41 AM, Staff 10 (CNA) stated Resident 1 was a hard core exit seeker. Staff 10 stated late on 7/3/25, Resident 1 had not slept and was not in the common area. Staff 10 stated Resident 1 was often in the common area in the evenings. On 10/23/25 at 2:03 PM, Staff 9 (CNA) stated Resident 1 threatened to remove her/his wander guard with a plastic knife prior to 7/4/25, and Staff 9 was unsure if the nurses were informed. On 10/23/25 at 3:21 PM, Staff 3 (RCM) stated she neglected to reassess and update Resident 1's care plan in 4/2025 when the resident attempted or threatened to leave. On 10/24/25 at 11:20 AM, Staff 8 (NP) expected frequent checks on Resident 1 since staff were aware of her/his escalated behaviors and desire to leave the facility.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review it was determined the facility failed to keep confidential all information contained in the resident's records, regardless of form for 1 of 3 sampled residents reviewed for discharge. This placed residents at risk for violation of their HIPPA privacy and security rights. Findings include: Resident 2 was admitted to the facility in 5/2025 with diagnoses including diabetes and a blood clot (thrombus). A 5/12/25 physician order indicated Resident 2 received Warfarin (anticoagulant) daily. On 5/30/25, Resident 2 was discharged from the facility. Staff 13 (LPN) stated she educated Resident 2 on the proper administration of her/his medications and placed the medications in a bag for her/him to take home. On 10/21/25 at 4:00 PM, Resident 2 stated when she/he returned to her/his residence from the facility, she/he reviewed the medications sent home and found another resident's anticoagulant (blood thinner) mixed within her/his bag. On 10/23/25 at 1:47 PM, Staff 2 (DNS) confirmed the photograph Resident 2 took of another resident's medication she/he received upon discharge. Staff 2 acknowledged this type of medication error should never occur.		