STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385137	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Plum Ridge Post Acute Rehab	1401 Bryant Williams Dr. Klamath Falls, OR 97601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on interview and record review it was determined the facility failed to provide SNF ABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage) notifications to 1 of 3 sampled residents (#13) reviewed for Beneficiary Notification. This placed residents and their representatives at risk for inadequate information to make financial and care decisions. Findings include:The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (ABN), Form CMS-10055, is issued by the facility if the beneficiary intends to continue services and the facility believes the services may not be covered under Medicare. It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services. Resident 13 was admitted to the facility in 12/2025 with Medicare Part A benefits.The SNF Beneficiary Notification Review form completed by the facility for Resident 13 indicated the resident's last covered day for Medicare Part A services was 2/18/26 and Resident 13 remained in the facility. Resident 13 was not provided with a SNF ABN for notification of potential financial liability for services received.On 5/21/26 at 3:57 PM, Staff 19 (Social Services Assistant) confirmed residents with Part A service termination who remain in the facility should be given a SNF ABN form in addition to a Notice of Medicare Non-Coverage. Staff 19 stated the SNF ABN was not completed for Resident 13.On 5/22/26 at 9:51 AM, Staff 1 (Administrator) acknowledged the facility failed to complete the required SNF ABN form for Resident 13.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that the facility failed to ensure sufficient bathing was provided to a dependent resident for 1 of 1 sampled resident (#70) reviewed for ADLs. This placed residents at risk for lack of personal hygiene. Findings included: Resident 70 was admitted to the facility on [DATE] with diagnoses including an open wound of the left buttock and respiratory failure with hypoxia (low oxygen levels in the blood making it difficult to breathe).The 5/11/26 and 5/14/26 Task Bath/Shower log (CNA documentation) revealed Resident 70 declined bathing on both dates.Resident 70's clinical record revealed no documentation of follow-up or interventions related to the resident's bathing refusals.A 5/12/26 admission Social Services assessment revealed a BIMS score of 15 (cognitively intact) for Resident 70.A 5/12/26 Care Plan revealed Resident 70 required one staff member to provide physical assistance for care, staff were to ensure the resident's clothing remained clean and appropriate, and the resident experienced anxiety related to feelings of confined spaces.A 5/14/26 Multidisciplinary Care Conference revealed Resident 70 required supervised assistance for safety and moderate assistance with ADLs including personal care tasks.On 5/18/26 at 7:28 AM and 5/20/26 at 11:21 AM, Resident 70 was observed sitting in her/his recliner wearing a gown. Resident 70 stated only one bed bath was offered since her/his admission which the resident declined at the time. Resident 70 stated she/he was unable to receive a shower because of her/his wound and received no bathing for one week. Resident 70 stated she/he requested bathing and there was no follow-up. Resident 70 stated she/he had not been offered a clean gown since admission and therapy was aware she/he felt trapped when the resident was in bed due to her/his breathing difficulties. On 5/20/26 at 1:07 PM, Staff 12 (LPN) stated all residents are on a bathing schedule. Staff 12 stated staff were to notify nurses of resident bathing refusals to allow nursing staff to address the resident's needs individually. Staff 12 stated he was not informed Resident 70 refused bathing on 5/11/26. Staff 12 stated communication was difficult that day because Staff 12 was assigned medication administration and nursing tasks due to staffing shortages. On 5/21/26 at 3:37 PM, Staff 17 (CNA) stated she informed Staff 21 Resident 70 wanted to sleep when a shower was offered on the evening of 5/11/26. On 5/21/26 at 5:00 PM, Staff 21 (RN) stated she was not notified Resident 70 refused a shower on 5/11/26. Staff 21 stated nurses were to speak directly with the resident, reschedule or address the shower refusal, and document a progress note when notified.On 5/22/26 at 8:48 AM, Staff 14 (CNA) stated she offered Resident 70 a bed bath on 5/14/26 and the resident did not want to transfer to the bed from her/his chair. Staff 14 stated she had three scheduled showers that day and Staff 12 was informed of Resident 70's refusal.On 5/22/26 at 8:56 AM, Staff 9 (Resident Care Manager) acknowledged she became aware Resident 70 did not receive a shower for one week after her/his admission. Staff 9 stated she expected follow-up communication with the resident by nurses. Staff 9 stated bathing was necessary for Resident 70 due to the resident's wounds. Staff 9 acknowledged improved communication and interventions were necessary to address Resident 70's bathing refusals.On 5/22/26 at 9:46 AM, Staff 2 (DNS) stated following a bathing refusal, notification to nurses was expected so they could address the resident directly, reapproach bathing, and document the resident's bathing status in a progress note.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to clarify and follow physician orders for 1 of 5 sampled residents (#3) reviewed for medications. This placed residents at risk for delayed treatment and unmet medication needs. Findings include:Resident 3 was admitted to the facility in 5/2024 with diagnoses including heart failure, atrial fibrillation (irregular heartbeat), and COPD (Chronic Obstructive Pulmonary Disease).The 4/2026 TAR revealed an order to obtain daily weights every day shift for Resident 3. No weights were documented on 4/16/26, 4/17/26 or 4/29/26 and weight increases exceeding two pounds were recorded as follows:-From 4/4/26 to 4/5/26: 2.2-pound increase-From 4/10/26 to 4/11/26: 3.8-pound increase-From 4/14/26 to 4/15/26: 4.8-pound increase-From 4/20/26 to 4/21/26: 2.4-pound increaseA 5/1/26 signed Medication Review Report indicated the order for daily weights every day shift was active, verbally prescribed, and had a start date of 8/1/24.The 5/2026 TAR revealed no daily weights were documented on 5/3/26, 5/9/26, 5/14/26, and 5/16/26. Resident 3 gained 10 pounds from 5/10/26 to 5/15/26.A 5/1/26 Note Text: Weight Warning identified Resident 3's weight had decreased during the week.A 5/14/26 Note Text: Weight Warning indicated Resident 3 had a small weight gain, nurses would monitor for the resident's trending weights, and notify the provider as needed.On 5/22/26 at 10:20 AM a handwritten note provided by Staff 2 (DNS) indicated Staff 7 (Doctor of Nursing Practice) expected staff to notify her when residents with orders for daily weights experienced a weight gain of two to three pounds within 24 hours or five pounds within one week. No additional documentation was found in Resident 3's clinical record. On 5/21/26 at 11:48 AM, Staff 5 (LPN) stated CNAs obtained Resident 3's daily weights. Staff 5 stated there were no documented parameters for Resident 3's daily weights and no weights were reported to Staff 7.On 5/21/26 at 12:17 PM and 4:29 PM, Staff 16 (Resident Care Manager) stated nursing staff were expected to clarify orders for Resident 3's daily weights and consistently assess weight fluctuations to ensure concerns regarding the resident's condition were addressed. Staff 16 stated staff were expected to reweigh residents when weight changes were considered significant but could not identify the specific weight parameters to address potential issues with Resident 3's weights. On 5/21/26 at 2:04 PM, Staff 7 stated there was an understanding that residents with heart failure should have daily weights according to her specified parameters. Staff 7 stated she was not notified when Resident 3's weights fell outside of those parameters.On 05/22/26 at 9:38 AM, Staff 2 acknowledged Resident 3's parameters for daily weights were not confirmed and the resident required reweighing with documentation on multiple days to monitor for potential health complications identified by the resident's weight fluctuations.

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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. Based on observation, interview, and record review it was determined the facility failed to provide appropriate treatment and services to prevent further decrease in range of motion for 1 of 1 sampled resident (#2) who was reviewed for positioning and mobility. This placed residents at risk for contracture progression and joint pain. Findings include: Resident 2 admitted to the facility in 8/2024 with diagnoses including cerebral infarction (stroke), hemiplegia/hemiparesis (reduced sensation and movement with abnormal muscle tone) of the left side, and depression.The 12/23/25 Care Plan Report for Resident 2 included a restorative nursing program which included range of motion exercises for the left leg. The restorative nursing program did not include interventions for the left arm or hand.The 2/8/26 Quarterly MDS for Resident 2 indicated intact cognition and impairment of range of motion of the upper and lower extremity on one side of the body.The most recent OT Evaluation & Plan of Treatment completed on 2/16/26, reflected impaired left upper extremity range of motion in the shoulder, elbow, wrist, fingers, and thumb. This document also stated Resident 2 once had an RA program for left upper extremity range of motion. The 3/19/26 OT Discharge Summary did not reflect a left upper extremity range of motion program was established prior to discharge.On 5/18/26 at 10:07 AM, Resident 2 indicated she/he used a piece of a foam pool noodle to try to expand her/his hand, but she/he was unable to find the pool noodle on this date. Resident 2's left hand was observed to have contractures of all fingers and was fixed in a cupped position. Resident 2 stated she/he tried to do stretching of the left hand for herself/himself and indicated staff do not assist her/him with range of motion of the left arm and hand. The door leading from the resident's room to the bathroom had a photograph posted of Resident 2's left upper extremity wearing a forearm/wrist/hand splint with instructions for the application of this device. Resident 2 stated she/he no longer used the splint in the photo. On 5/19/26 at 12:35 PM Resident 2 indicated she/he had still not located the pool noodle to place in her/his left hand to stretch out the contractures of the fingers. Instead, she/he put a washcloth in her/his left hand.On 5/19/26 at 3:03 PM, Staff 25 (CNA) stated she provided no special care for Resident 2's left hand or wrist.On 5/20/26 at 10:01 AM, Staff 27 (CNA) indicated the care she offered to Resident 2 for her/his left hand was routine hand hygiene and nail care. Staff 27 did not know if Resident 2 ever had a range of motion or contracture management program for the left upper extremity.On 5/20/26 at 10:26 AM, Staff 26 (Director of Rehabilitation and Occupational Therapy Assistant) confirmed Resident 2 had no range of motion program in place for the left upper extremity.On 5/21/26 from 11:28 AM to 11:49 AM, Resident 2 was lying in bed with a pink memory foam block in her/his left hand. Resident 2 expressed feelings of sadness and cried at times during this conversation. Resident stated she/he suffered from depression and sometimes she/he just gives up on exercise programs and other things she/he knows she/he should be doing. Resident 2 expressed difficulty remaining motivated when she/he feels depressed and stated she/he needed staff to come in and remind, encourage, and assist her/him with doing stretches and exercises. Resident 2 explained therapy staff trained her/him with programs in the past for exercise and range of motion but once she/he discharged from skilled therapy, no staff regularly assisted with carrying out those programs.On 5/21/26 at 1:13 PM, Staff 16 (RCM) indicated the facility expectation was for CNA staff to provide RA programs to residents as part of their daily ADL care. Staff 16 stated the facility did not have any RA personnel on staff. Staff 16 confirmed the photo and instructions for the left arm/hand splint posted in Resident 2's room was outdated and no longer in use.On 5/22/26 at 10:22 AM, Staff 2 (DNS) stated the posted left arm/hand splint information in Resident 2's room should have been taken down, as the splint was discontinued a long time ago. Staff 2 confirmed Resident 2 needed to receive left upper extremity range of motion support to prevent decline.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review it was determined the facility failed to ensure a resident who was a trauma survivor was assessed timely and received trauma-informed care for 1 of 4 sampled residents (#3) reviewed for choices. This placed residents at risk for continued traumatization. Findings include:Resident 3 was readmitted to the facility in 5/2024 with diagnoses including heart failure and PTSD (Post-Traumatic Stress Disorder).A 5/2/22 admission: Social Services assessment revealed Resident 3 had PTSD related to military service. The assessment indicated the resident's coping mechanisms included to try not to think about it and attendance at a PTSD support group. No revised assessment related to the resident's PTSD was found in the clinical record.Resident 3 was readmitted to the facility in 2/2026.A 2/9/26 admission: Social Service assessment did not address Resident 3's PTSD diagnosis, triggers, or coping mechanisms.The 2/27/26 Quarterly MDS assessment revealed Resident 3 had a BIMS assessment score of 15 (cognitively intact).The 4/22/26 to 5/21/26 Task: Behavior Monitoring and Interventions (documentation by CNAs) revealed Resident 3 had no behaviors.A 5/15/26 revised Care Plan revealed Resident 3 experienced a sad or depressed mood related to PTSD and may be triggered by flashbacks of violent wartime events. Resident 3 attended a veteran support group with transportation provided by her/his family. The care plan did not identify loud noises as PTSD triggers.On 5/18/26 at 10:49 AM, Resident 3 was observed seated in her/his wheelchair in her/his room. Resident 3 was asked about her/his triggers related to her/his trauma. Resident 3 appeared to become agitated, developed a furrowed brow, and stated loud noises and noises from the neighbor bothered her/him as the resident pointed toward the wall shared with the neighboring room. Resident 3 stated staff were aware of the issue. Resident 3 stated she/he no longer attended her/his veterans therapy group and missed the support previously received. Resident 3 stated she/he was recently provided a bus pass to attend the veterans therapy group. On 5/19/26 at 3:46 PM, Staff 24 (CNA) stated she was aware of Resident 3's anxiety related to the noises from neighboring residents. Staff 24 stated she provided distraction techniques listed in her/his care plan to address the resident's anxiety associated with her/his PTSD several times each month.On 5/20/26 at 3:00 PM, Staff 19 (Social Service Assistant) stated Resident 3 was a long-term resident and no recent interview related to the resident's PTSD was completed. Staff 19 stated the facility was aware of concerns about Resident 3's neighbors but did not address her/his concerns because no formal complaint was submitted. Staff 19 stated Resident 3 was provided a bus pass to assist with transportation needs for attendance at the veteran support group and was not aware the resident did not attend.On 5/21/26 at 10:30 AM, Staff 18 (Social Services Assistant) stated Resident 3 was not interviewed regarding PTSD needs upon readmission. Staff 18 acknowledged the resident's care plan was updated using an outdated Social Services assessment. Staff 18 expected an annual review of Resident 3's trauma informed care needs to ensure the resident had sufficient transportation to attend the veterans support group and a potential room change related to noise concerns.On 5/21/26 at 10:51 AM, Staff 20 (Corporate Social Service Consultant) acknowledged an updated assessment for Resident 3's PTSD was not completed upon admission, staff were to assess and communicate behavioral concerns, and newly identified triggers were not incorporated into the resident's care plan. On 5/21/26 at 11:30 AM, Staff 23 (CNA) acknowledged loud noises annoyed Resident 3 and staff addressed the concerns by keeping the peace between residents. Staff 23 stated she did not consider Resident 3's responses as behaviors because the resident did not raise her/his voice. Staff 23 stated nurses were aware Resident 3 had PTSD; however, the resident's care plan did not include details about her/his triggers.On 5/21/26 at 11:36 AM, Staff 5 (LPN) stated Resident 3 complained about noise disturbances and he was informed social services staff would address the concerns with the resident. Staff 5 stated he was not aware of any triggers related to Resident 3's PTSD and acknowledged the resident's repeated complaints about noise were signs of agitation and behaviors which should be documented.On 5/21/26 at 12:02 PM, (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff 3 (CNA) stated Resident 3 reported noise concerns which were reported to nursing. Staff 3 acknowledged Resident 3 was agitated when she/he complained about the noises and acknowledged those behaviors were not documented.On 5/21/26 at 12:33 PM, Staff 16 (Resident Care Manager) stated Social Services staff were expected to address Resident 3's PTSD and acknowledged it was an interdisciplinary responsibility to ensure the resident's care plan was updated to reflect changes in triggers and psychosocial needs related to PTSD.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **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 proper food temperatures were maintained during meal service for 3 of 13 sampled residents (#s 26, 52, and 70) reviewed for dining observations. This placed residents at risk for food that was not palatable or appetizing. Findings include: 1. Resident 26 was admitted to the facility in 3/2026 with diagnoses including compression fracture of the spine and respiratory failure. An 4/1/26 admission MDS revealed a BIMS assessment score of 14 (cognitively intact). Resident 70 was admitted to the facility in 5/2026 with diagnoses including kidney failure and diabetes. A 5/12/26 admission Social Services assessment revealed a BIMS score of 15 (cognitively intact). A 5/18/26 untitled document indicated Resident 70 was to receive early breakfast trays daily. On 5/18/26 at 7:25 AM an uninsulated open cart containing three covered resident meal trays was observed unattended in the hallway. On 5/18/26 at 7:40 AM, Resident 70 stated she/he ate in her/his room and the food was cold 50% of the time. Resident 70 stated meal trays were often left undelivered outside her/his room for an extended period of time. On 5/18/26 at 7:45 AM, one unidentified staff member was observed to deliver the resident meal trays from the open cart. A large, enclosed cart arrived at the same time with additional resident meal trays. On 5/18/26 at 8:06 AM, three unidentified staff members were observed to deliver meal trays to residents including Resident 26. On 5/18/26 at 8:16 AM, Resident 26 was observed eating breakfast in her/his room. The meal included fried eggs and toast. Resident 26 stated the food was barely warm. An unidentified staff member entered the room and removed the resident's plate to reheat the toast and fried eggs in the microwave. On 5/20/26 at 9:00 AM, Staff 29 (CNA) stated the breakfast meal tray delivery process involved the delivery of early trays first, then the delivery of the remaining meal trays to the dining room and resident rooms once the larger meal cart arrived. Staff 29 stated it was difficult to deliver breakfast meal trays timely when CNAs were occupied providing resident care. Staff 29 stated nurses were not available to assist with the early meal tray deliveries. On 5/20/26 at 10:09 AM, Staff 28 (Dietary Manager) stated therapy created a list of residents who required early trays in order to attend morning therapy sessions and additional residents were added to the early tray list based on dialysis schedules. Staff 28 stated early meal trays were completed daily at approximately 7:20 AM and the current meal carts were not insulated which made it difficult (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to maintain food temperatures without prompt delivery. Staff 28 acknowledged delayed tray delivery could result in cold food and reheated food decreased food quality. On 5/22/26 at 10:32 AM, Staff 1 (Administrator) acknowledged addressing resident concerns related to cold food remained an ongoing focus of the facility's QAPI (Quality Assurance Performance Improvement) program. 2.Resident 52 was admitted to the facility in 8/2025 with diagnoses including dialysis and diabetes. On 5/18/26 at 7:25 AM, an uninsulated open cart was observed with three covered resident meal trays on the cart. No staff were in attendance. On 5/18/26 at 8:21 AM, a meal tray for room [ROOM NUMBER] was observed in the kitchenette on the counter and not refrigerated. The resident in room [ROOM NUMBER] was not in the room On 5/18/26 at 11:25 AM, Resident 52 stated she/he was supposed to receive an early breakfast due to going out to dialysis and being an early riser, but she/he did not get her/his tray delivered early. Resident 52 stated she/he watched the meal tray sit on the meal cart undelivered. Resident 52 stated staff would warm the meal up, which made the food mushy and taste awful. Resident 52 also stated, sometimes I get my breakfast when I return from dialysis and staff warm the food up, which makes the food worse. On 5/20/26 at 9:00 AM, Staff 29 (CNA) stated she left Resident 52's meal tray in the kitchenette on the counter because there was no room in the refrigerator and she would reheat the meal for her/him once she/he returned after 10:00 AM. On 5/20/26 at 10:09 AM, Staff 28 (Dietary Manager) stated therapy created a list of residents who required early trays to attend morning therapy sessions and additional residents were added to the early tray list based on dialysis schedules. Staff 28 stated early meal trays were completed daily around 7:20 AM. Staff 28 stated the current meal carts were not insulated and it was difficult to maintain food temperatures without prompt delivery. Staff 28 acknowledged he was aware of the potential issue of cold food with late meal tray delivery and reheated food decreased food quality. 05/21/26 8:10 AM, Resident 52 stated she/he did not receive an early tray that morning. She/he sat in the tv room, observed the meal cart, and the early morning trays were not passed. On 5/22/26 at 10:32 AM, Staff 1 (Administrator) acknowledged cold food experienced by residents in the facility was an ongoing focus of the Quality Assurance Performance Improvement (QAPI) program

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review it was determined the facility failed to follow proper infection control techniques during medication administration via feeding tube for 1 of 1 sampled resident (#7) reviewed for medication administration. This placed residents at risk for acquiring an infection. Findings include:The 2009 Administration of Medication via a Feeding Tube indicated, in order to administer medications via a feeding tube, staff were to gather supplies, which included: prepared medication, sterile water, towel or absorbent pad, 60ml syringe, and gloves. Staff were to perform hand hygiene and follow necessary infection control guidelines. This prevented the spread of harmful pathogens. Exposure to bodily fluids and blood would be present, so standard precautions should have been taken.Resident 7 was admitted to the facility in 5/2025 with diagnoses including quadriplegia (paralysis of all four limbs) and required the use of a feeding tube for medication administration.On 5/20/26 at 4:39 PM, Staff 13 (CMA) was observed to prepare medication to administer in Resident 7's feeding tube. Staff 13 did not place a clean barrier on the bedside table before she placed the medication cup with the medication, fluids to mix the medication before administration via the feeding tube, and a syringe which was used to administer medication into the resident's feeding tube. On 5/20/26 at 5:00 PM, Staff 13 acknowledged she did not place a clean barrier on the bedside table before she placed medication, fluids, and the syringe which were used to administer medication into the resident's feeding tube.On 5/20/26 at 5:14 PM, Staff 1 (Administrator) and Staff 2 (DNS) acknowledged Staff 13 should have placed a clean barrier on the bedside table before she placed medication, fluids, and the syringe which were used to administer medication into Resident 7's feeding tube.