STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385141	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis MT Tabor	6040 SE Belmont Street Portland, OR 97215

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents were free from sexual abuse for 1 of 3 sampled residents (#202) reviewed for abuse. This placed residents at risk for abuse. Findings include: Resident 202 was admitted to the facility in 4/2024 with diagnoses including hemiplegia (paralysis that affects only one side of the body). Resident 202's 4/5/24 Admission: Social Services Assessment indicated the resident was cognitively intact. Resident 201 was admitted to the facility in 2/2024 with diagnoses including unspecified psychosis (a collection of symptoms that affect the mind where there has been some loss of contact with reality). Resident 201's 2/21/24 Socially Inappropriate Sexual Behavior Care Plan revealed the following: -The resident's socially inappropriate sexual behaviors included showing photos of her/his private parts and exposing her/himself to staff. -The resident masturbated in her/his room with the door open. Resident 201's 2/23/24 Admission MDS indicated the resident was moderately cognitively impaired. The Behavioral Symptoms CAA indicated the resident had experienced delusions, sexual behaviors and verbal behaviors since her/his admission to the facility. The CAA further indicated the resident yelled, cursed and encouraged staff to look at her/his penis. A 4/8/24 Progress Note revealed Resident 201 attended a movie at the facility on 4/6/24 at 2:30 PM during which she/he masturbated. The resident who sat next to Resident 201 requested to leave the movie. A 4/8/24 Witness Statement completed by Staff 3 (RNCM) revealed Staff 8 (CNA) reported to her that Staff 8 was informed by another unnamed CNA that Resident 201 and Resident 202 attended a movie on 4/6/24 during which Resident 201 pulled down her/his pants and masturbated. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER Marquis MT Tabor		STREET ADDRESS, CITY, STATE, ZIP CODE 6040 SE Belmont Street Portland, OR 97215	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/24 at 9:44 AM Staff 7 (RN) stated she worked as the charge nurse on 4/6/24 and heard that a resident may have exposed her/himself and was sexually inappropriate during a movie. Staff 7 stated she did not have a recollection of who told her, when she was told or any additional details about the incident. Staff 7 stated she should have asked more questions and started an investigation. Staff 7 stated she found out the details of this incident on 4/8/24 and was informed she should have reported this incident as it was considered sexual abuse. On 4/11/24 at 10:11 AM Staff 8 stated Resident 201 had exhibited sexually inappropriate behaviors since her/his admission to the facility which included masturbating in her/his room with the door open, masturbating while staring at staff and exposing her/his private parts in common areas. Staff 8 stated the resident never wanted [her/his] door closed and would get mad if you closed [her/his] door. Staff 8 stated the resident sat in the hallways with a gown on and her/his legs open, exposing his private parts. Staff 8 stated Staff 6 (CNA) informed her Resident 202 reported to her on 4/7/24 that Resident 201 actively masturbated in front of Resident 202 during a movie on 4/6/24 while staring at the resident. Staff 8 stated she told Staff 6 to inform the nurse of this incident but was not sure if Staff 6 reported it. Staff 8 stated she informed Staff 3 on 4/8/24 of the incident that occurred between Resident 201 and Resident 202 on 4/6/24 and stated the incident was considered abuse. On 4/11/24 at 10:25 AM Resident 201 was observed in her/his room in her/his wheelchair. The resident was observed to independently move in her/his wheelchair and drink from her/his coffee cup. Resident 201 stated she/he could not remember if she/he exposed and/or inappropriately touched her/himself during a movie on 4/6/24. Resident 201 stated she/he had been previously accused of inappropriately touching her/himself in front of another resident at a different nursing facility. On 4/11/24 at 10:39 AM Resident 202 was observed in her/his room sitting in her/his wheelchair. Resident 202 stated she/he was involved in an incident over the past weekend when a guy was playing with [her/himself] during a movie and kept looking at me like do you want to do it for me? Resident 202 stated she/he sat next to Resident 201 during the movie and she/he tried to ignore Resident 201 but she/he just stared at me and made me feel uncomfortable. Resident 202 stated an activity staff member was present during the activity but was not close by. Resident 202 stated she/he reported the incident to Staff 6 (CNA) on 4/7/24, the day after the incident occurred, because she/he was new to the facility, worried about reporting and did not know what to do. On 4/11/24 at 11:02 AM Staff 5 (Activities Assistant) stated Resident 201 and Resident 202 were in attendance for the movie on 4/6/24, the residents sat next to one another and Resident 201 wore a hospital gown. Staff 5 stated she observed Resident 202 to back away from the movie in her/his wheelchair so she checked on the resident. Staff 5 stated Resident 202 repeated she/he wanted to go back to her/his room. On 4/11/24 at 11:57 AM Staff 6 stated Resident 201 often sat in the doorway of her/his room and in common areas with her/his private areas visible. Staff 6 stated Resident 201 would frequently wear a gown and raise it up so that her/his private areas would show and would scream at staff when asked to cover her/himself. Staff 6 stated Resident 202 reported to her on 4/7/24 during a movie, another resident sat next to her/him and played with [her/himself] and kept looking at [her/him] and it made [Resident 202] feel uncomfortable. Staff 6 stated she reported this incident to Staff 7 and Staff 8 on 4/7/24. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/24 at 12:59 PM Staff 3 stated Resident 201 was observed to sit outside of the door to her/his room and pull her/his gown all the way up so you could see [her/his] scrotum and penis just after her/his admission to the facility, and on several occasions, Resident 201 was observed to masturbate outside of her/his room while she/he stared at staff. Staff 3 stated she was not informed of the incident that occurred during the movie on 4/6/24 until 4/8/24 by Staff 8. Staff 3 stated she interviewed Resident 201 about the incident who indicated she/he was not going to argue the point, it happened. On 4/11/24 at 3:03 PM Staff 2 (DNS) acknowledged the findings of this investigation and stated Resident 201's parts were out, [she/he] was inappropriate and it made [Resident 202] uncomfortable.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47000 Based on interview and record review it was determined the facility failed to timely report allegations of abuse to the State Survey Agency for 2 of 3 sampled residents (#s 201 and 202) reviewed for abuse. This placed residents at risk for delayed and incomplete investigations. Findings include: The facility's 10/2022 Reporting Abuse to Facility Management Policy directed the following: -Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Administrator. -When an alleged or suspected case of abuse is reported, the facility Administrator or her/his designee will notify the State licensing/certification agency responsible for surveying/licensing the facility within two hours of the allegation being made. Resident 202 was admitted to the facility in 4/2024 with diagnoses including hemiplegia (paralysis that affects only one side of the body). Resident 202's 4/5/24 Admission: Social Services Assessment indicated the resident was cognitively intact. Resident 201 was admitted to the facility in 2/2024 with diagnoses including unspecified psychosis (a collection of symptoms that affect the mind where there has been some loss of contact with reality). Resident 201's 2/23/24 Admission MDS indicated the resident was moderately cognitively impaired. The facility's 4/8/24 FRI form, completed by Staff 3 (RNCM) revealed the following: -Resident 201 and Resident 202 attended a movie with the activities department on 4/6/24 at 2:30 PM. -During the movie, Resident 201 pulled down her/his pants and masturbated while she/he looked at Resident 202. -Resident 202 informed Staff 5 (Activity Assistant) she/he wanted to return to her/his room. -Resident 202 did not inform Staff 5 about the incident because she/he was afraid but the resident told a CNA upon her/his return to her/his unit in the building. -The SA (state agency) was notified of the incident on 4/8/24 at 8:21 AM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Marquis MT Tabor		STREET ADDRESS, CITY, STATE, ZIP CODE 6040 SE Belmont Street Portland, OR 97215	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/24 at 9:44 AM Staff 7 (RN) stated she worked as the charge nurse on 4/6/24 and heard a resident may have exposed her/himself and was sexually inappropriate during a movie. Staff 7 stated she did not have a recollection of who told her, when she was told or any additional details about the incident. Staff 7 stated she should have asked more questions and started an investigation. Staff 7 stated she found out the details of this incident on 4/8/24 and was informed she should have reported this incident as it was considered sexual abuse. On 4/11/24 at 10:11 AM Staff 8 (CNA) stated Staff 6 (CNA) informed her Resident 202 reported to Staff 6 on 4/7/24 that Resident 201 actively masturbated in front of Resident 202 during a movie on 4/6/24 while staring at Resident 202. Staff 8 stated she told Staff 6 to inform the nurse of this incident but was not sure if Staff 6 reported it. Staff 8 stated she informed Staff 3 on 4/8/24 of the incident that occurred between Resident 201 and Resident 202 on 4/6/24. On 4/11/24 at 10:39 AM Resident 202 stated she/he was involved in an incident over the past weekend when a guy was playing with [her/himself] during a movie and kept looking at me like do you want to do it for me? Resident 202 stated she/he reported the incident to Staff 6 (CNA) on 4/7/24, the day after the incident occurred, because she/he was new to the facility, worried about reporting and did not know what to do. On 4/11/24 at 11:57 AM Staff 6 stated Resident 202 reported to her on 4/7/24 during a movie on 4/6/24, another resident sat next to her/him and played with [her/himself] and kept looking at [her/him] and it made [Resident 202] feel uncomfortable. Staff 6 stated she reported this incident to Staff 7 and Staff 8 on 4/7/24. On 4/11/24 at 12:59 PM Staff 3 stated she was not informed of the incident that occurred during the movie on 4/6/24 until 4/8/24 by Staff 8. Staff 3 stated as soon as the incident was reported, she informed the DNS and initiated a FRI. On 4/11/24 at 3:20 PM Staff 1 (Administrator) confirmed the FRI was not reported timely and she would have expected the FRI have been completed and submitted to the state within two hours after the staff were informed of the incident between Resident 201 and Resident 202 on 4/7/24.