STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385180	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Newberg	441 Werth Blvd Newberg, OR 97132

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review it was determined the facility failed to ensure the responsible party was involved in decisions related to the resident's day to day activities for 1 of 1 sampled resident (#46) reviewed for resident rights and care planning. This placed residents at risk for their representatives not being informed of the resident's health status. Findings include: Resident 46 was admitted to the facility on 7/2025 with diagnoses including anoxic brain damage (The brain lacks oxygen causing the brain cells to die permanently). A 10/27/25 Quarterly MDS indicated Resident 46 had a BIMS of 7 indicating severe cognitive impairment. A 11/20/25 Court Order indicated Witness 2 (Guardian) was appointed guardianship for Resident 46.Progress Notes reviewed from 11/29/25 through 12/7/25 indicated Resident 46 left the facility with her/his friend on two occasions. No evidence was found to indicate Witness 2 was notified of Resident 46 leaving the facility. On 1/12/26 at 11:43 AM, Witness 2 stated he was frustrated and concerned because the facility allowed Resident 46 to leave the facility with friends. Witness 2 stated the facility didn't tell him about Resident 46 leaving. Witness 2 stated Staff 1 (Administrator) and Staff 3 (LPN Resident Care Manager) were aware and agreed to notify him. Witness 2 was concerned because Resident 46 wanted to go home and feared she/he would elope back home.On 1/14/26 at 10:56 AM, Resident 46 stated she/he was allowed to leave the facility anytime and was expected to return by sunset. Resident 46 stated she/he didn't care about notifying her/his health representative when leaving the facility.On 1/15/26 at 11:30 AM, Staff 6 (CNA) stated Resident 46 was allowed to leave the facility with friends. Resident 46 notified nursing when leaving the facility. On 1/15/26 at 12:46 PM, Staff 7 (LPN) stated Resident 46's cognition was not good and she/he wasn't allowed to make decisions independently. Staff 7 stated Witness 2 was her/his guardian. Staff 7 acknowledged Witness 2 was not notified when Resident 46 left the building but Witness 2 was required to be notified due to Resident 46's impaired cognition.On 1/16/26 at 9:18 AM, Staff 3 stated Witness 2 was required to be notified when Resident 46 left the facility. Staff 3 stated Witness 2 was concerned when Resident 46 left with friends and requested the facility provide education for friends and requested notification about out of facility outings. On 1/16/26 10:29 AM, Staff 1 stated Witness 2 had specific concerns and requests for Resident 46 prior to leaving the facility. Staff 1 stated floor staff were expected to notify Witness 2 before Resident 46 left the building with friends and thought a communication plan was added on the care plan. Staff 2 stated floor staff were aware notification was required since Witness 2 was Resident 46's guardian.

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 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 ensure ordered services were obtained to increase ROM for 1 of 2 sampled residents (#46) reviewed for mobility and choices. This placed residents at risk for decreased mobility. Findings include:Resident 46 was admitted to the facility in 7/2025 with diagnoses including hemiplegia (paralysis to one side of the body) and suicidal ideation. A 10/27/25 Quarterly MDS indicated Resident 46 had a BIMS of 7 indicating severe cognitive impairment. A 9/30/25 Orthopedic After Visit Summary indicated Resident 46 had significant tightness and shortening of her/his left knee hamstrings (muscles that help bend the knee, extending the hip and walking). Resident 46 required aggressive daily therapy and was required to use a range of motion brace. Resident 46 was to start a contracture training program.A 1/12/26 Provider Note indicated Resident 46 was waiting for an outpatient contracture management appointment. On 1/12/26 at 11:43 AM, Witness 2 (Health Representative) stated Resident 46 graduated from physical therapy and required outpatient services. Witness 2 stated an outpatient referral was entered in July 2025 but he didn't hear back from the facility with updates. Witness 2 stated Resident 46 required an outpatient contracture training program for left leg contractures. Witness 2 stated Resident 46 stopped walking since physical therapy ended and he asked for alternative physical activities, but staff didn't communicate any plans. On 1/14/26 at 10:56 AM, Resident 46 stated she/he graduated from physical therapy and stated she/he dragged her/his left foot while walking due to lost muscle tone.On 1/15/26 at 12:46 PM, Staff 7 (LPN) stated Resident 46 didn't perform daily exercises and was unsure about recent outpatient orthopedic appointments. On 1/16/26 at 9:06 AM, Staff 10 (OT Rehab Director) stated Resident 46 stopped working with physical therapy because she/he required an outpatient contracture management program. On 1/16/26 at 9:18 AM, Staff 3 (LPN Resident Care Manager) stated Resident 46 was referred to outpatient orthopedic services on 8/29/25 for left leg contractures. Staff 3 stated staff hit a dead end and Resident 46 didn't have a scheduled appointment. Staff 3 stated Resident 46 didn't wear a range of motion brace and one was not ordered. Staff 3 acknowledged care was delayed for Resident 46. On 1/16/26 at 11:45 AM, Staff 2 (Interim DNS) stated staff were expected to follow up after residents returned from outpatient appointments. Staff 2 acknowledged Resident 46 was not scheduled for an orthopedic outpatient appointment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to perform hand hygiene for 1 of 1 sampled resident (#6) reviewed for pressure ulcers. This placed the resident at risk for cross contamination. Findings include:A 11/2022 Wound Care -Level II Policy indicated performing hand hygiene after removing gloves was expected. Resident 6 was admitted to the facility on [DATE] with diagnoses including diabetes.A 1/2026 TAR indicated Resident 6 had a facility acquired pressure ulcer on her/his coccyx (the last bone at the bottom of the spine) and had daily wound care orders. On 1/15/26 at 10:34 AM, Staff 8 (LPN) and Staff 9 (Hospice CNA) entered Resident 6's room and performed wound care. Staff 8 and Staff 9 repositioned Resident 6 onto the right side. Staff 8 removed the old dressing, removed her gloves and applied new gloves. Staff 8 did not perform hand hygiene. Staff 8 finished packing the wound with gauze and removed her gloves and new gloves were applied. Staff 8 did not perform hand hygiene. Staff 8 applied a new dressing. Staff 8 removed her gloves and new gloves were applied. Staff 8 did not perform hand hygiene. After wound care, Staff 9 performed personal hygiene for the resident, changed Resident 6's brief, obtained clean linen from the bathroom, removed linen and applied new linen and she did not change her gloves. On 1/15/26 at 10:50 AM, Staff 8 stated she did not perform hand hygiene because her hands weren't visibly soiled and she didn't have hand sanitizer. Staff 8 stated she completed hand hygiene after care and not in-between changing gloves. Staff 9 stated she did not touch the dirty linen so gloves were changed before leaving the room. Staff 8 acknowledged Staff 9 touched the dirty linen. On 1/16/26 at 11:45 AM, Staff 2 (Interim DNS) stated she expected staff to perform hand hygiene after removing gloves.