

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Marquis Centennial Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SE 202nd Avenue Portland, OR 97233	

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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>46053</p> <p>Based on interview and record review it was determined the facility failed to provide a written Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) in a timely fashion for 1 of 3 sampled residents (#47) reviewed for Beneficiary Protection Notification. This placed residents at risk for unknown financial liabilities. Findings include:</p> <p>Resident 47 was admitted to the facility in 2/2024 with diagnoses including dementia (loss of cognitive functioning) and emphysema (a lung condition that causes shortness of breath).</p> <p>A review of resident 47's 4/1/24 quarterly MDS revealed she/he had impaired short- and long-term memory loss and moderately impaired decision-making skills.</p> <p>On 5/1/24 at 2:27 PM Staff 10 (Admission Director) stated Resident 47's last covered day of Medicare Part A services was 4/1/24.</p> <p>A review of Resident 47's medical record revealed the facility provided Resident 47's representative with a Notice of Medicare Non-Coverage on 4/1/24.</p> <p>On 5/3/24 at 10:37 AM Staff 1 (Administrator) stated, We should be giving residents 48 hour notice so they are aware of the change.</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47000</p> <p>Based on observation, interview and record review it was determined the facility failed to protect the resident's right to be free from physical abuse by another resident for 2 of 5 sampled residents (#s 34 and 29) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>1. Resident 34 was admitted to the facility in 1/2020 with diagnoses including history of traumatic brain injury and mental disorder due to a known physiological (related to the body) condition.</p> <p>Resident 34's 1/27/20 Socially Inappropriate Behavior Care Plan indicated the following:</p> <ul style="list-style-type: none"> -The resident may get too physically close to others and talk nonstop to them. -The resident required reminders and encouragement to provide a safe distance between her/himself and others. -The resident may need to be redirected away from others should she/he talk too much, make negative/inappropriate statements, become an irritant to others or make inappropriate accusations towards others. <p>Resident 34's 4/5/22 Quarterly MDS revealed the resident was severely cognitively impaired.</p> <p>Resident 47 was admitted to the facility in 6/2023 with diagnoses including dementia with psychotic disturbance and PTSD (post-traumatic stress disorder: a mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety).</p> <p>Resident 47's 6/12/23 Social Services Admission Assessment revealed the resident took quetiapine (an atypical antipsychotic used to treat schizophrenia, psychosis and bipolar disorder) for behaviors and sertraline (an antidepressant) for PTSD.</p> <p>Resident 47's 6/18/23 Admission MDS indicated the resident was severely cognitively impaired.</p> <p>Resident 47's 6/19/23 Care Plan indicated the following:</p> <ul style="list-style-type: none"> -The resident was a veteran. -The resident experienced poor insight and safety awareness. <p>a. A 7/2/23 Resident to Resident Event Assessment and Staff Questionnaire revealed the following:</p> <ul style="list-style-type: none"> -Resident 47 and Resident 34 walked down the hall towards their rooms when Resident 34 stated I have the right to be outside to which Resident 47 responded with don't come at me with that attitude. -Resident 47 pushed Resident 34 at chest level which caused Resident 34 to fall backwards and land on her/his left side. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident 34 sustained a superficial left elbow and left knee abrasion (a rub or wearing off of the skin) as a result of this incident.</p> <p>-Resident 47 visited with her/his spouse in the courtyard prior to the incident.</p> <p>-Resident 34 walked out to the courtyard despite staff encouragement to wait inside until Resident 47 finished her/his visit.</p> <p>On 4/29/24 at 10:51 AM Resident 47 was observed in the dining room sitting in her/his wheelchair. The resident was unable to answer any questions regarding the incident that occurred on 7/2/23.</p> <p>On 4/29/24 at 10:57 AM Resident 34 was observed in her/his room seated in a chair. The resident was unable to answer any questions regarding the incident that occurred on 7/2/23.</p> <p>On 4/30/24 at 9:32 AM Witness 1 (Spouse) stated when Resident 47 admitted to the facility she/he did not want anyone near her/him and would lash out at others who came into her/his space. Witness 1 stated Resident 47 did not like Resident 34 because she/he would try to insert her/himself into their family situations.</p> <p>On 5/1/24 at 11:10 AM Staff 26 (CNA) stated Resident 47 and Resident 34 had issues prior to the incident that occurred on 7/2/24. Staff 26 stated Resident 47 did not like that Resident 34 would speak to Witness 1, and because of this, she tried to distract Resident 34 if she knew Witness 1 was visiting.</p> <p>On 5/1/24 at 2:06 PM Staff 20 (RN) stated on 7/2/23 Resident 34 went outside to the courtyard while Witness 1 and Resident 47 visited despite asking Resident 34 to remain inside until their visit was finished. Staff 20 stated later on, and after Witness 1 left the facility, both residents walked down the hall when Resident 34 started in about [her/his] right to be outside following which Resident 47 stated I am not going to let anybody talk to me like that and I am not going to put up with that. Staff 20 stated Resident 47 then placed her/his hands on Resident 34's chest and pushed her/him down. Staff 20 stated Resident 34 sustained minor injuries from the incident and was tearful.</p> <p>On 5/2/24 at 8:58 AM Staff 18 (LPN) stated Resident 47 was irritated with [Resident 34] because of [her/his] attention-seeking behaviors prior to the incident on 7/2/23, which was why she would not sit them together at the same table.</p> <p>On 5/2/24 at 11:46 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the findings of this investigation. Staff 1 confirmed Resident 47 pushed Resident 34 and Resident 34 sustained two abrasions as a result of the altercation.</p> <p>b. Resident 34's 7/4/23 Care Plan revealed the following:</p> <p>-The resident was not to sit at the same table or close to Resident 47 unless provided with one-to-one supervision.</p> <p>-The resident had a history of making uninvited/unwanted verbal accusations towards Resident 47 as well as threats of physical harm to others.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 47's 8/1/2023 Care Plan revealed the following:</p> <ul style="list-style-type: none"> -Resident 34 may have trauma as a result of her/his experience in the military. -Trauma triggers included loud noises, fast movements from others and other resident behaviors. -The resident experienced physical aggression and abusive behavior, including pushing and shoving others as well as grabbing body parts of others (ie: shoulders, neck and arms). -Staff were to be cognizant (aware) of staff and other residents not invading her/his personal space. -If aggressive, staff were to try and remove the resident from the area and provide an individualized program with low stimulus. <p>Resident 47's 8/30/23 Behavior Assessment indicated the resident's mental status could change throughout the day and she/he frequently presented with confusion and delusional thinking. The assessment also indicated the resident would occasionally exhibit aggressive posturing and verbalizations towards other residents, staff and environmental stimuli, such as loud noises or other resident behaviors.</p> <p>A 10/15/23 Resident to Resident Event Assessment revealed the following:</p> <ul style="list-style-type: none"> -Resident 34 was in the dining room watching television when she/he was approached by Resident 47. -Resident 47 accused Resident 34 of being a thief and then grabbed Resident 34 around the neck and put her/his hand over Resident 34's face. -Two staff members immediately intervened and separated the residents. -Resident 34 was not injured. -Prior to this event, Resident 47 appeared sad and confused. -Resident 47 may have confused the voice on the television for Resident 34. <p>On 4/29/24 at 10:51 AM Resident 47 was observed in the dining room sitting in her/his wheelchair. The resident was unable to answer any questions regarding the incident that occurred on 10/15/23.</p> <p>On 4/29/24 at 10:57 AM Resident 34 was observed in his room seated in a chair. Resident 34 could not recall any issues or altercations with other residents and stated she/he felt safe in the facility.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/1/24 at 11:10 AM Staff 26 (CNA) stated she was present during the altercation that occurred between Resident 34 and 47 in 10/2023. Staff 26 stated at the time of the incident in 10/2023, both residents were in the dining room watching television. Staff 26 stated Resident 47 put her/his hand on Resident 34's walker, Resident 34 stated it [was] mine, don't take it and then Resident 47 was instantly up on her/his feet and put Resident 34 in a choke hold with her/his right arm and put her/his left hand over the resident's face. Staff 26 stated she helped to pry Resident 47's arms off of Resident 34 and separated the residents. Staff 26 stated Resident 34 had red marks on the left side of [her/his] neck and on the right side of [her/his] forehead after the altercation.</p> <p>On 5/1/24 at 2:51 PM Staff 28 (Agency CNA) stated she worked on 10/15/23 and was told during shift change that Resident 47 did not have a good attitude that day. Staff 28 stated Resident 34 and Resident 47 were in the dining room watching a movie when Resident 47 turned to Resident 34 and stated What did you say? in response to a loud comment made on the television. Resident 47 then yelled at Resident 34 that's my son's sweater and the two residents engaged in a grappling situation. Staff 28 stated Resident 47 put Resident 34 in a choke hold and Resident 34 yelled at her/him to stop. Staff 28 stated the residents were separated and Resident 34 was scared and complained of facial pain.</p> <p>On 5/2/24 at 11:46 AM Staff 1 (Administrator) and Staff 2 (DNS) acknowledged the findings of this investigation. Staff 1 confirmed Resident 47 placed Resident 34 in a choke hold but stated Resident 34 did not experience any lasting negative impact from the altercation as she/he could not recall the incident days later.</p> <p>38140</p> <p>2. Resident 43 admitted to the facility in 6/2023 with diagnoses including dementia with a behavioral disturbance.</p> <p>Resident 43's 12/9/23 Significant Change of Condition MDS assessed her/him with a BIMS score of five (severe cognitive impairment).</p> <p>Resident 29 was admitted to the facility in 8/2023 with diagnoses including dementia without behaviors.</p> <p>Resident 29's 2/21/24 Quarterly MDS assessed her/him with moderate cognitive impairment.</p> <p>Review of Resident 29's health record revealed on 11/21/23 at 3:20 PM Staff 5 (RNCM) noted swelling and discoloration to Resident 29's upper lip and Resident 29 indicated another resident hit her/him.</p> <p>A 11/21/23 written statement from Staff 24 (LPN) revealed on 11/20/23 Staff 23 (CNA) reported when she walked past Resident 29 and Resident 43's shared room, she observed Resident 43 to stand over Resident 23. Staff 23 immediately reported to Staff 24 and Staff 24 went to the residents' room. Staff 24 observed Resident 43 to stand next to her/his own bed while she/he looked at a Bible. Staff 24 did not observe any damage or wound on Resident 23's face prior to this reported incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 11/27/23 an incident investigation revealed on 11/20/23 Resident 43 punched Resident 29 in the face while Resident 29 rested in her/his bed. When interviewed, Resident 23 recalled Resident 43 stood over her/him with no indication of what prompted the situation, and Resident 43 did not say anything before or after she/he hit Resident 23 on the face. The facility was not aware of the incident until 11/21/23 when the discoloration and swelling occurred on Resident 23's upper lip.</p> <p>On 5/2/24 at 12:09 PM Staff 1 (Administrator) acknowledged the incident between Resident 23 and Resident 43. Staff 1 stated she expected all residents to be free from abuse.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>38140</p> <p>Based on observation, interview and record review the facility failed to conduct a new/accurate Level I PASARR when the facility became aware of indicators of a serious mental illness diagnoses and failed to complete a referral for a Level II PASARR (Pre-Admission Screening and Resident Review) for 1 of 5 residents (# 46) reviewed for medications. This placed residents with a mental health disorder at risk for delayed care, emotional distress related to mental illness and lack of services to attain their highest practicable well-being. Findings include:</p> <p>Resident 46 admitted to the facility in 6/2023 with diagnoses including Psychotic Disorder with delusions (mental condition), Delusional Disorder (serious mental condition making it difficult to tell what is real), Dementia with behaviors, Post Traumatic Stress Disorder, Major Depressive Disorder and anxiety.</p> <p>A PASARR 1 (no indication of a serious mental illness) was completed from the hospital upon admission on 6/23/23 for Resident 46.</p> <p>Resident 46's current care plan directed staff with interventions for the following behavioral concerns:</p> <ul style="list-style-type: none"> - Delusions; - Physical aggression; -Verbal aggression; - Socially inappropriate behaviors; - Resistive coming out of room; - Paranoid/ repetitiveness/demanding/anxious behavior; - History of suicidal behavior; - Wander/ elopement risk. <p>Progress Behavioral notes reviewed from 4/3/24 to 5/2/24 revealed 12 occasions when Resident 46 slammed doors, yelled at others and made negative statements.</p> <p>Review of Resident 46's health record provided no evidence needed to complete a correct Level I PASARR or to make a referral for a Level II PASARR for behavioral services.</p> <p>On 5/1/24 from 7:49 AM to 2:16 PM Resident 46 was observed on multiple occasions to self isolate in her/his room.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/3/24 at 10:59 AM Staff 1 (Administrator) stated she worked closely with the Social Services staff to complete the Level II PASARR referrals. Staff 1 acknowledged Resident 46's Level I PASARR was coded incorrectly. Staff 1 acknowledged she would expect Resident 46 to be identified as a person who needed a Level II PASARR with the dignoses and behaviors she/he experienced and a referral should be initiated. No additional information was provided.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>46053</p> <p>Based on observation, interview and record review it was determined the facility failed to develop a person centered comprehensive care plan for 1 of 1 resident (#53) reviewed for communication. This placed residents at risk for unmet care needs. Findings include:</p> <p>Resident 53 was admitted to the facility in 3/2024 with diagnoses including non-traumatic subarachnoid hemorrhage (intracranial bleeding) and type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>A review of Resident 53's 3/26/24 Admission MDS revealed she/he had moderate cognitive impairment and needed an interpreter to communicate with her/his doctor or facility staff.</p> <p>Resident 53's care plan dated 3/28/24 indicated her/his primary languages were Chinese/Taiwanese/Cantonese and she/he had impaired communication skills related to a language barrier.</p> <p>On 5/1/24 at 10:06 AM Resident 53 was observed in the dining room speaking loudly in Chinese to Staff 22 (CNA). Staff 22 removed a cup of liquid from the table and stated as she walked away, I don't know what she means. Staff 22 returned to the table with a cup of hot tea and Resident 53 was heard to verbalize in Chinese. Staff 22 was observed to shrug her shoulders and walked away.</p> <p>On 5/1/24 at 10:30 AM Staff 22 said It's trial and error when communicating with Resident 53. Staff 22 said she never saw a translator and said she thought it was an app for use on a tablet.</p> <p>On 5/2/24 at 11:08 AM Staff 22 stated Resident 53 did not have a communication board. She entered Resident 53's room and found a three-ring binder with communication pictures at her/his bedside. She looked through the images depicting care needs, emotions, questions, and responses and stated, These are all good. It has emotions and actions. Staff 22 stated she did not know Resident 53 had it. Staff 22 stated, It is not in [her/his] care plan.</p> <p>No evidence was found in Resident 22's care plan to indicate the communication binder was available as a communication aide.</p> <p>On 5/2/24 at 11:15 AM Staff 5 (RNCM) stated Resident 53 spoke a specific dialect which the voice translation app did not recognize. She confirmed Resident 53's care plan was not revised when she/he received the communication binder.</p> <p>On 5/2/24 at 11:54 AM Staff 12 (SSD) stated she expected Resident 53's communication binder to be added to her/his care plan so it was visible in the Kardex for staff to use it as a communication aide.</p> <p>On 5/3/24 at 10:32 AM Staff 1 (Administrator) stated she expected communication aides to be included in residents' care plans so staff know to use them.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47000</p> <p>Based on interview and record review it was determined the facility failed to follow physician orders for 1 of 5 sampled residents (#47) reviewed for unnecessary medications. This placed residents at risk for unmet needs. Findings include:</p> <p>Resident 47 was admitted to the facility in 6/2023 with diagnoses including heart failure.</p> <p>Resident 47's 4/2024 Physician Orders directed the following:</p> <ul style="list-style-type: none"> -Obtain daily weights for heart failure, every day shift. -Notify physician if the resident gained three pounds in 24 hours or five pounds in a week. <p>A review of Resident 47's 4/2024 Weight Summary revealed the following days without a recorded weight:</p> <ul style="list-style-type: none"> -4/2/24 -4/3/24 -4/4/24 -4/5/24 -4/8/24 -4/9/24 -4/12/24 -4/17/24 -4/18/24 -4/19/24 -4/20/24 -4/26/24 -4/30/24 <p>On 5/3/24 at 8:30 AM Staff 19 (CNA) stated Resident 47 was to be weighed daily and she/he rarely refused.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/3/24 at 8:33 AM Staff 18 (LPN) stated Resident 47 was weighed daily because she/he had heart failure and the resident did not typically refuse. Staff 18 stated nurses were expected to document in the resident's progress notes the reason why a weight was not obtained for a resident with an order for scheduled weights. Staff 18 reviewed Resident 47's electronic record and confirmed the weights and progress notes with a reason as to why the weights were not obtained were missing on the days noted above. Staff 18 stated CNAs did not always inform her when they were unable to obtain Resident 47's weights, so she did not always know to write a progress note.</p> <p>On 5/3/24 at 9:11 AM Staff 2 (DNS) stated she thought Resident 47 was cooperative with being weighed and she/he was to be weighed daily. Staff 2 stated nurses were expected to notify Resident 47's physician on those occasions when a weight was not obtained in order to receive further instructions. Staff 2 reviewed Resident 47's clinical record and confirmed weights were not completed according to the resident's physician's orders.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46053</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure staff followed the care plan related to fall safety and provide sufficient supervision to prevent a fall for 2 of 2 sampled residents (#s 306 and 47) reviewed for accidents. This failure resulted in resident 306 having a fall with serious injury including a left shoulder fracture, a rib fracture and periprosthetic fracture involving the left greater trochanter (fracture of a previously-repaired hip) which required emergency medical services and treatment at the hospital. Findings include:</p> <p>1. Resident 306 was admitted to the facility 1/2023 with diagnoses including right leg fracture and right shoulder fracture.</p> <p>A review of Resident 306's 1/17/23 admission MDS revealed she/he was cognitively intact and required extensive assistance from two or more staff to transfer on and off the toilet.</p> <p>Resident 306's care plan dated 1/11/23 directed caregivers to provide her/him with two person stand pivot physical assist to transfer and to encourage her/him not to ambulate without assistance.</p> <p>On 5/1/24 at 5:28 PM Staff 25 (Agency CNA) stated on 5/7/23 she responded alone to Resident 306's call for assistance. Staff 25 stated Resident 306 told her she wanted to use the commode in her/his bathroom. Staff 25 stated she asked Resident 306 what she needed to do to help her/him and Resident 306 told her she/he only needed her/his cane. Staff 25 stated she offered to get her/his wheelchair but Resident 306 told her she was only there to help with her/his pants. Staff 25 stated Resident 306 walked to the bathroom, leaned forward to lock the door to the adjoining resident room and fell forward hitting her/his head and landing on her/his left side.</p> <p>On 5/1/24 at 6:06 PM Resident 306 stated Staff 25 assisted her/him to the bathroom using a manual wheelchair on 5/7/23 without the assistance of any other caregiver. She/he stated Staff 25 did not provide her/him with a gait belt to transfer. Resident 306 stated she/he stood up to transfer to the commode in her/his bathroom, tried to lock the door to the adjoining bathroom and fell forward hitting her/his head and landing on her/his left side. Resident 306 stated, I think she was pulling the wheelchair out when I was trying to do that and it tripped me.</p> <p>On at 5/1/24 5:38 PM Staff 27 (LPN) stated she worked with Resident 306 on 5/7/23 and Staff 25 provided care alone for her/him at the time of the fall. Staff 27 stated she expected CNAs to consult residents' care plans or Kardex before working with the resident and the Kardex tells how they transfer, ambulate and toilet. That is what they should be following. Staff 27 reported they called 911 because she/he was in an awkward position and they were not confident they could get her up and the paramedics could assess [her/him] for other injuries.</p> <p>A review of Resident 306's hospital notes revealed she/he was sent to the emergency department on 5/7/23 after she/he fell in the facility. Resident 306 was sent back to the facility but then returned and was admitted to the hospital on 5/9/23 and treated for anemia and the following injuries she/he sustained as a result of the fall on 5/7/23:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Marquis Centennial Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 725 SE 202nd Avenue Portland, OR 97233	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Left shoulder fracture</p> <p>-5th rib fracture</p> <p>-periprosthetic fracture involving the left greater trochanter (fracture of a previously-repaired hip)</p> <p>Resident 306's Hospital Discharge Summary indicated she/he was discharged from the hospital and returned to the facility on [DATE].</p> <p>A review of the facility's internal investigation completed by Staff 1 on 5/12/23 revealed Staff 25 did not follow Resident 306's care plan at the time of the fall.</p> <p>On 5/3/24 at 10:28 AM Staff 1 stated she expected CNAs to follow residents' care plans and Staff 25 knew where to find Resident 306's transfer status but did not follow it.</p> <p>47000</p> <p>2. Resident 47 was admitted to the facility in 6/2023 with diagnoses including dementia with a behavioral disturbance.</p> <p>Resident 47's 6/18/23 Admission MDS revealed the resident was severely cognitively impaired and not steady when moving from a seated to a standing position or when walking. The MDS also revealed the resident experienced a fall in the month prior to her/his admission to the facility, a fall in the two to six months prior to her/his admission to the facility and a fracture related to a fall in the six months prior to her/his admission to the facility.</p> <p>a. A review of Resident 47's clinical record revealed the resident experienced a fall in her/his room on 2/9/24 and 2/16/24 as a result of a failed attempt to self-transfer.</p> <p>Resident 47's 2/2024 Care Plan revealed the resident was at risk for falls related to her/his cognitive impairment, history of falls, lack of impulse control and unsteady gait (a person's manner of walking). The Care Plan indicated the resident was not to be left unsupervised in her/his room while awake as [Resident 47] may attempt to self-transfer to/from bed/wheelchair.</p> <p>Resident 47's 4/13/24 Fall/Post Fall Assessment revealed the following:</p> <p>-The resident experienced a fall at 2:30 AM in the resident's room.</p> <p>-The resident was in bed prior to the fall and found two feet from the transfer surface to the location of the fall.</p> <p>-A CNA found the resident with her/his hands resting on her/his roommate's bed with her/his right knee on the ground.</p> <p>-The resident was unable to provide a description of the fall event.</p> <p>-The new preventative plan was to perform frequent checks.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The following questions from the Assessment were left unanswered:</p> <ul style="list-style-type: none"> -When [was the resident] last visually observed? -When [was the resident] last toileted? -When [was the resident] last offered fluids? -When [was the resident] last repositioned? <p>On 5/1/24 at 12:33 PM Staff 16 (LPN) stated she completed Resident 47's Fall/Post Fall Assessment on 4/13/24. Staff 16 stated she usually asked the resident's assigned CNA questions regarding care provided prior to a resident's fall but failed to do so in the case of Resident 47's fall on 4/13/24. Staff 16 stated staff typically checked on Resident 47 every few hours on night shift, and when Resident 47 was awake, she/he required eyes on [her/him] at all times because she/he was at risk for falls.</p> <p>On 5/1/24 at 2:37 PM Staff 17 (CNA) stated Resident 47 was considered a high fall risk and she usually checked on her/him around 11:30 PM to 12:00 AM and again around 2:00 AM. Staff 17 stated she found Resident 47 on 4/13/24 in her/his room kneeling down on one knee at [her/his] roommate's bed and could not recall when she last visually observed Resident 47, last toileted Resident 47, last offered Resident 47 fluids or last repositioned Resident 47 prior to this fall. Staff 17 stated she was not asked to provide any of these details at any point after the fall.</p> <p>On 5/2/24 at 8:58 AM Staff 18 (LPN) stated when Resident 47 was in bed, she expected CNAs to walk by the resident's room about every 10 minutes because she/he was a huge fall risk. Staff 18 stated sometimes [Resident 47] would stand up and the pressure light [would] not go off so it [was] really important staff [walked] the halls.</p> <p>On 5/2/24 at 12:09 PM Staff 2 (DNS) was informed of the findings of this investigation and stated doing rounds [was] the best way to prevent a resident from having falls. Staff 2 stated she expected staff to be peeking in resident rooms at least every 30 minutes when doing walking rounds at night.</p> <p>b. Resident 47's 4/30/2024 Care Plan revealed the resident was at risk for falls related to her/his cognitive impairment, history of falls, lack of impulse control and unsteady gait (a person's manner of walking). The Care Plan indicated the resident was not to be left unsupervised in her/his room (while awake) as [Resident 47] may attempt to self-transfer to/from bed/wheelchair and a pressure sensitive call light [was] to be placed between the bed fitted sheet and draw sheet to the left side of the resident when in bed for a fall intervention.</p> <p>A review of Resident 47's clinical record revealed the resident experienced a fall in her/his room on 2/9/24, 2/16/24 and 4/13/24 as a result of a failed attempt to self-transfer.</p> <p>On 4/30/24 at 12:47 PM Staff 19 (CNA) was observed to leave Resident 47's room, which left the resident alone in her/his room in bed. From the hallway, the resident was observed with her/his eyes open, lifted up her/his neck, looked around the room and moved her/his lips. Resident 47 removed her/his bedding from the top half of her/his body and stuck her/his right hand into the slats of the blinds on the right side of her/his bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/30/24 at 12:49 PM Staff 19 knocked on Resident 47's door to which the resident yelled yes and laughed as Staff 19 entered the room. Resident 47 and Staff 19 engaged in conversation, Staff 19 recovered the resident with her/his bedding and left the room. Resident 47 was observed to talk to her/himself as Staff 19 left the room.</p> <p>On 4/30/24 at 12:51 PM Resident 47 was observed to remove the bedding from the upper part of her/his body and sit up in bed. Resident 47 scooted her/himself to the edge of her/his bed. At 12:54 PM Resident 47 placed both of her/his feet on the ground, and with a hand to each side of her/his waist, began to rock as if attempting to initiate a sit-to-stand transfer. The State Surveyor entered the resident's room and activated her/his pressure sensitive call light. At 12:55 PM Staff 19 returned to the resident's room and was informed of the resident's movements and that the pressure sensitive call light did not activate independently.</p> <p>On 4/30/24 at 1:02 PM Staff 19 stated Resident 47 experienced multiple falls and was the one [he] mainly worried about. Staff 19 stated when Resident 47 was awake and in [her/his] room, [she/he] would mostly likely stand up. Staff 19 stated Resident 47 was not supposed to be left alone in her/his room if she/he was awake. Staff 19 confirmed Resident 47 was awake when he re-entered the resident's room at 12:49 PM and he should have assisted the resident out of bed and brought her/him to an area where she/he could have been supervised.</p> <p>On 5/1/24 at 11:10 AM Staff 26 (CNA) stated Resident 47 was a fall risk because she/he tried to stand up independently all of the time but was unable to do so safely now that her/his toes were removed. Staff 26 stated if Resident 47 was awake, she preferred [her/him] to have supervision.</p> <p>On 5/1/24 at 2:06 PM Staff 20 (RN) stated Resident 47 was considered a fall risk as she/he was impulsive and did not remember she/he required assistance with transfers. Staff 20 stated Resident 47 would lose her/his balance as soon as she/he stood and tried to move from a spot with her/his right foot due to having her/his toes amputated. Staff 20 stated if Resident 47 was restless in bed, which included moving her/his blankets around, staff should offer to assist the resident out of bed.</p> <p>On 5/2/24 at 12:09 PM Staff 2 (DNS) acknowledged the findings of this investigation and stated if Resident 47 was moving around in bed, her expectation was for the CNA to check if Resident 47 was soiled, and if not, assist her/him up out of bed.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>43691</p> <p>Based on observation, interview and record review it was determined the facility failed to perform post-dialysis assessments on 1 of 1 sampled residents (#33) reviewed for dialysis. This placed residents at risk for unidentified complications related to dialysis treatment. Findings include:</p> <p>Resident 33 was admitted to the facility in 6/2019 with diagnoses including end stage renal disease (kidney dysfunction).</p> <p>A 2/16/22 Physician Order stated nursing staff were to assess Resident 33's vital signs and write a progress note when she/he returned to the facility from dialysis.</p> <p>A 4/2/24 Quarterly MDS indicated Resident 33 had normal cognitive function.</p> <p>On 4/30/24 at 12:15 PM Resident 33 stated her/his vitals and port site (dialysis access site) are often not checked by facility staff after she/he returned from dialysis.</p> <p>Review of 4/2024 progress notes revealed no post-dialysis assessments were completed for Resident 33 on:</p> <p>-4/15/24, -4/17/24, -4/19/24, -4/22/24, -4/24/24 and -4/26/24.</p> <p>On 5/3/24 at 10:11 AM Staff 21 (LPN) stated post-dialysis assessments were to be performed immediately after a resident returns from dialysis. Staff 21 stated these assessment included checking respiratory rate, heart rate, blood pressure and the port site for any abnormalities. Staff 21 stated these assessments were documented in progress notes.</p> <p>On 5/3/24 at 10:14 AM Staff 2 (DNS) confirmed post-dialysis assessments were not performed and documented immediately upon Resident 33's return to the facility from dialysis on the dates listed above.</p>