STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385183	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Centennial Post Acute Rehab	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to provide maintenance to maintain a safe, comfortable and homelike environment for 1 of 1 facility reviewed for physical environment. This placed residents at risk for an unsafe and unkempt interior building. Findings include: 1. Observations of the facility's general environment from 8/18/25 through 8/22/25 identified the following issues: -Eight of eight hanging light fixtures in the dining room contained multiple dead insects visibly trapped inside the covers. -Two visibly dusty portable oscillating fans, positioned on each side of the dining room tables and approximately six feet away from the seated residents, were actively blowing air toward them. -Nine of nine floor vents in the dining room were coated in thick layers of dust, debris and visible cobwebs. -A visibly dirty floor fan placed on top of a refrigerator was operating and blowing air across multiple zones in the kitchen including the coffee maker station, an area with dirty dishes and a clean area containing a rack with sanitized pitchers, food containers and cutting boards. -A ceiling vent in the south hallway, just outside room [ROOM NUMBER], showed a significant buildup of dust and cobwebs. On 8/20/25 at 11:16 AM Staff 1 (Administrator) and Staff 8 (Maintenance Director) acknowledged the identified concerns needed to be addressed. 2. Resident 17 was admitted to the facility in 7/2025 with diagnoses including pneumonia (inflammation and fluid in your lungs caused by bacterial, viral or fungal infection). The 7/22/25 admission MDS indicated Resident 63 was cognitively intact. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/18/25 at 10:05 AM, Resident 17 stated the shower room residents used was covered in mold. Resident 17 reported to staff a black substance on the floor in the shower room. Resident 17 was worried about the health risks when the shower room was used. Resident 17 stated the shower room was dirty and dangerous and thought the black substance would kill anyone who used it. Resident 17 stated staff attempted to clean the black substance with a towel, but the floor was still dirty. On 8/18/25 at 10:05 AM, the shower rooms were observed. The shower in the east hall was unkept. A gray and white substance was observed along the walls. The shower faucet was covered in a goldish brown substance and was rusty. The tile on the floor was peeled off and the floor was black and slimy. The shower drain lid was loose. The shower drain was covered in a black substance. The black substance was a mixture of hair and black liquid. The bottom baseboard around the door inside the shower room had a deep dent. The baseboard was peeled with unpainted sections. The white rack shelf on the wall was covered in a brown rusty substance and clean linen were stored on top of the white shelf. The handle to turn on the water was wiggly. The fan inside the shower room was covered in gray and black lint. On 8/18/25 at 10:20 AM, The south hall shower room’s fans were observed covered in dark gray and black lint. On 8/19/25 at 2:39 PM, Staff 16 (CNA) stated Resident 17 showed her the black substance on the floor in the shower room during her/his shower. Staff 16 attempted to clean the substance using a towel, which became stained during the process. The floor was also noted to be stained. Staff 16 stated Resident 17 was concerned about the black substance. Staff 16 acknowledged the black and rusty color throughout the shower walls and on the floor. Staff 16 stated the faucet to turn on the water was loose. She stated the handle was loose and was unable to adjust the temperature safely. On 8/20/25 at11:27 AM, Staff 1 (Administrator) acknowledged the shower room was unkept. Staff 8 (Housekeeping/Laundry/Maintenance Director) stated the shower was audited once a month. Staff 8 stated the shower handle in the shower room continued to break. Staff 8 stated the fans in the shower rooms were replaced a couple of months ago. 3. On 8/18/25 at 12:10 PM and 8/20/25 at 7:37 AM Resident 3’s room was observed with scratches of missing paint on the wall to the right of her/his bed. Resident 3 stated she/he was bothered by the scratches on the wall. On 8/20/25 at 11:16 AM Staff 1 (Administrator) and Staff 8 (Maintenance Director) acknowledged the scratching of missing paint on Resident 3’s wall and it required attention.

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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. **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 implement a physician order on the care plan for thickened liquids for 1 of 1 sampled resident (#36) investigated for hydration. This placed residents at risk for choking and aspiration. Findings include: Resident 36 was admitted to the facility in 5/2024 with diagnoses including dysphagia (difficulty in swallowing). The Annual MDS dated [DATE] indicated Resident 36 was cognitively impaired for decision-making and independent for eating and drinking after set-up.On 7/23/25 Resident 36 returned from the hospital with orders for mildly thickened liquids. Resident 36's 7/23/25 Nutrition Care Plan did not include the current mildly thickened fluid status.On 8/19/25 at 11:36 AM Resident 36 was observed with a large plastic cup of liquid within reach on her/his bedside table. Staff 13 (CNA) confirmed the cup in Resident 36's room contained thin liquids. On 8/21/25 at 11:28 AM a white paper cup was observed on the resident's nightstand. Staff 26 (CNA) confirmed the cup contained thin liquids.On 8/19/25 at 12:01 PM, 8/21/25 at 11:15 AM, & 8/21/25 at 11:15 AM, Staff 28 (CNA), Staff 21 (CNA), and Staff 27 (CNA) stated they were unaware Resident 36 was on mildly thickened liquids.On 8/21/25 at 1:00 PM Staff 5 (RNCM) stated the care plan did not reflect the physician orders for mildly thickened liquids. Staff 5 stated the care plan was used to inform direct care staff of the resident's care needs, led some staff to believe resident was on thin liquid.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review it was determined the facility failed to ensure foods were labeled in a way to minimize food spoilage in 1 of 2 unit refrigerators and safe food storage handling techniques for 1 of 1 meal service reviewed for kitchen. This placed residents at risk for potential infections related to foodborne pathogens and cross contamination. Findings include:1. On 8/21/25 at 9:38 AM observations of the facility's East unit refrigerator revealed the following items: an undated plastic container with a meal ticket on top dated 8/11/25, a plastic container dated 8/11/25, an undated container of spaghetti, and an undated container of rice with mixed vegetables. On 8/21/25 at 9:45 AM, Staff 9 (Dietary Manger) stated housekeeping was responsible for the maintenance of facility unit refrigerators. On 8/21/25 at 11:40 AM, Staff 34 (Housekeeper) stated she was unaware of the polices for food storage in facility's unit refrigerators. On 8/21/25 at 11:49 AM, Staff 8 (Maintenance Director) stated a designated housekeeper cleaned the facility's unit refrigerators once a week and was also expected to discard food items that were undated or were more than three days old. Staff 8 further stated the last time the East unit refrigerator was cleaned was on 8/14/25 and was next scheduled to be cleaned on 8/25/25 as the designated housekeeper was away. On 8/22/25 at 9:57 AM and 10:01 AM, Staff 1 (Administrator) stated the East unit refrigerator was used for resident food items and was cleaned by housekeeping every 72 hours. Staff 1 stated she expected housekeeping to ensure food items found in the East unit refrigerator were dated and discarded appropriately after three days. 2. On 8/18/25 at 9:29 AM during a tour of the facility's kitchen, a covered container of ice was observed with an ice scoop located inside. When asked, Staff 32 (Dietary Aide) stated inside the covered container was used to prepare ice water for residents. On 8/20/25 at 11:20 AM during meal tray service, Staff 33 (Dietary Aide) was observed using an ice scoop without gloves to prepare cups of ice water and proceeded to place the ice scoop back inside the container, on top of the ice, when not in use. On 8/20/25 at 1:17 PM Staff 33 confirmed she placed the ice scoop inside the container of ice when not in use and was unaware of an alternative process. On 8/20/25 at 1:44 PM Staff 9 (Dietary Manager) stated kitchen staff were expected to store the ice scoop separate from the container of ice when they prepared ice water for residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure infection control practices were implemented for 2 of 2 residents (#1 and 18) reviewed for catheter care and pressure ulcers pressure ulcer. This placed resident at risk for infection. Findings include: The facility's 3/2024 Isolation- Categories of Transmission-Based Precautions Policy specified the following: Residents with open complex wounds that require a dressing are included in EBP (enhanced barrier precautions) per CDC guidelines. PPE (personal protective equipment) is donned prior to high contact activity like bathing and wound care. 1.Resident 18 was admitted to the facility in 7/2025 with diagnoses including cerebral infarction (A lack of blood flow to the brain). The 7/31/25 Care Plan indicated EBP was initiated on 8/20/25. On 8/18/25 through 8/21/25 from 9:00 AM to 4:00 PM no signs were posted outside Resident 18’s room to indicated staff were to follow EBP. On 8/18/25 at 10:04 AM, Resident 18 was observed in her/his wheelchair in her/his room with the left leg elevated. Resident 18 wore a hinged knee brace on her/his left leg. The leg was wrapped with abdominal gauze dressing. The left foot was swollen, and the skin was purple and red. On 8/18/25 at 10:06 AM, Resident 18 stated she/he always wore a hinged knee brace and had a facility acquired wound behind her/his left calf Resident 18 stated staff performed wound care in her/his room several times during the week. Resident 18 stated PT removed the brace in her/his room to rub her/his leg. On 8/20/25 at 9:00 AM, Staff 15 (CNA) stated she did not wear PPE prior to providing a bed bath because Resident 18 was not on enhanced barrier precautions. On 8/20/25 at 9:36 AM, Staff 18 (LPN) stated Resident 18 had a wound to the back of her/his calf and wound care was provided on Monday, Tuesday and Wednesday. Staff 18 stated she did not wear EBP because the resident's wound was not infected. On 8/20/25 at 11:09 AM, Staff 4 (RNCM) stated Resident 18 had a wound with fluid and drainage oozing from the site, but was contained within the dressing. Staff 4 stated staff were not required to don PPE because the amount of drainage from the wound was light and the fluid was contained. On 8/20/25 at 12:17 PM, Staff 14 (Regional Nurse Consultant) stated Resident 18 had a wound and staff were required to don PPE when high activities like a bed bath and wound care were performed. Staff 18 acknowledged Resident 18’s medical record was updated on 8/20/25 and enhanced barrier precaution was initiated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 1 admitted to the facility in 2015 with a diagnosis including bladder obstruction. Resident 1’s 6/1/25 Quarterly MDS revealed she/he required an indwelling (urine) catheter. On 8/18/25 at 10:30 AM, 8/19/25 at 11:56 AM, 2:19 PM and 2:24 PM, and 8/20/25 at 2:46 PM, Resident 1 was observed to sit in her/his wheelchair in the activity room. Resident 1 had a urine catheter bag under her/his wheelchair with the tubing from the bag and up the left pant leg. The catheter tubing was on the floor and multiple staff passed by the resident. On 8/20/25 at 1:24 PM Staff 30 (CNA) stated Resident 1’s urine catheter tubing should not touch the floor while the resident was it her/his wheelchair. Staff 30 stated if she observed Resident 1's catheter tubing on the floor she would pick it up immediately. On 8/20/25 at 3:11 PM Staff 4 (Resident Care Manager/LPN) confirmed Resident 1’s urine catheter tubing was on the floor. Staff 4 stated she expected staff to ensure Resident 1's catheter tubing was not on the floor.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, interview, and record review it was determined the facility failed to ensure a bed was in good repair for 1 of 5 sampled residents (#8) reviewed for unnecessary medications. This placed residents at risk for potential injury. Findings include:Resident 8 was admitted to the facility in 4/2025 with diagnoses including generalized anxiety disorder and malnutrition. Resident 8's 7/21/25 Quarterly MDS revealed the resident was cognitively intact. On 8/18/25 at 10:38 AM, Resident 8 stated the foot board of her/his bed was broken and had not been fixed. A review of maintenance work orders from 7/1/25 through 8/18/25 revealed no evidence a request was submitted for Resident 8's foot board to be repaired. On 8/19/25 at 2:43 PM, Resident 8 was observed placing pressure on the left side of the foot board, which was unsecured and elevated the right side of the bed. The resident stated the foot board was broken since 8/11/25. On 8/19/25 at 3:13 PM, Staff 16 (CNA) stated she was aware Resident 8's foot board was broken on 8/11/25 when she noticed it was no longer secured to the bedframe after the resident used it to assist herself/himself with a transfer. Staff 16 stated she reinserted the foot board into the bedframe, but it remained unsecured if too much pressure was applied. Staff 16 was unaware if maintenance was notified of the broken foot board. On 8/20/25 at 3:48 PM, Staff 31 (Nursing Assistant) stated she noticed a week prior the foot board was not secured to the bedframe and reinserted it. Staff 31 stated she did not notify maintenance of the broken foot board. On 8/21/25 at 10:35 AM Staff 8 (Maintenance Director) stated staff were expected to report broken furniture and equipment in residents' rooms as an electronic maintenance request during their shift.