STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385204	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Forest Grove Post Acute Rehab	3300 19th Avenue Forest Grove, OR 97116

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review it was determined the facility failed to ensure staff adhered to professional standards during medication administration for 1 of 1 licensed nurse (#3) reviewed for significant medication error. Resident 49 required emergency treatment and was hospitalized for monitoring due to a methadone overdose. Findings include:Resident 49 admitted to the facility in 2021 with diagnoses including COPD and diabetes. Staff 3's employee file indicated on 10/13/25 education was provided regarding where to find crushed medication orders for Resident 49. The education was provided because Staff 3 gave whole medications to the resident and she/he choked on the whole medications. Resident 49's orders were reviewed with Staff 3. Resident 49's medications were to be crushed in applesauce as described in the special instructions.The 11/3/25 8:37 AM signed medication error report written by Staff 3 (LPN) indicated the following: This LN [licensed nurse] asked CNA in dining room who room [Resident 41] was and when she pointed with her head it was towards [Resident 49], so this LN gave methadone to [Resident 49] instead of [Resident 41], no side effects noted at this time. Unclear which patient was pointed at, seemed like this patient's direction was pointed at. The 11/3/25 11:10 AM progress note by Staff 2 (DNS) indicated the following: Called [physician] to report change in condition. Resident somnolent and with slurred speech. Taken back to room and developed nausea/vomiting. Awake and talking during episode. Alert and oriented self and place with history of dementia, unchanged level of orientation from baseline. Blood pressure 180/64, pulse 52, respirations 14, oxygen saturation 96% on room air. New orders to administer Narcan nasal spray 4 mg x 1, and Zofran [antiemetic medication] 4 mg po x 1. Call physician back if no improvement after Narcan administration. Resident was assisted into bed and closely monitored.The 11/3/25 11:40 AM progress note by Staff 2 indicated the following: Resident no longer with emesis, however, remains with GI upset and stating 'I don't feel good.' Heart rate 44 and irregular, pauses noted when listening to apical pulse. Heart rate 44, respirations 18, oxygen saturation 95% on room air. One liter oxygen per nasal canula placed and [the physician] called back .and ordered to transfer the resident to the emergency room for monitoring and evaluation.The 11/7/25 facility investigation indicated the following:-On 11/3/25 at approximately 8:30 AM a medication error occurred, Staff 3 administered Resident 41's methadone 40 mg to Resident 49. -At 11:45 AM the provider was again contacted due to continued changes in condition and instructed staff to send to the emergency room for hospital evaluation.-At 11:53 AM, 911 was called and Resident 49 was transferred to the hospital for evaluation and was subsequently admitted for further monitoring.-The licensed nurse responsible for the medication error was educated by Staff 2 (DNS) on the five rights of medication administration, starting with their photo identification on record and verification of name. Staff 3 was subsequently placed on administrative leave pending investigation.-In conclusion, the investigation determined that the licensed nurse did not follow proper resident identification procedures and failed to confirm the resident's identity prior to medication administration. As a result, the incorrect medication was administered, leading to Resident 49 requiring hospital evaluation and continued monitoring. Staff 3 was terminated from employment. The 11/7/25 hospital records indicated Resident 49 was hospitalized for a primary diagnosis of accidental methadone overdose and bradycardia (slow heart rate). On 4/9/26 at 9:34 AM Staff 3 stated she (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Actual harm Residents Affected - Few	remembered the incident when Resident 49 received Resident 41's methadone medication. She stated the resident was not in her/his room and she went to the dining room and asked CNA staff who Resident 49 was and they pointed her to the resident sitting up. Staff 3 stated she asked the resident if she/he was Resident 41's name and the resident stated Yes, yes, yes. She was unaware Resident 49 had confusion. Staff 3 stated she gave Resident 49 the liquid methadone medication and the nurse that was in the dining room told her that was not the correct resident and she did not administer additional medications to the resident. Staff 3 stated she then reported the medication error to the resident care managers. She stated she heard about the pulse being 44 and stated Staff 2 sent Resident 49 to the hospital.On 4/9/26 at 10:17 AM Staff 4 (LPN) stated on 11/3/25 she was in the dining room assisting a resident with a meal and heard Staff 3 say she could not crush medications, then observed Staff 3 next to Resident 49 with a medication cup with Resident 41's room number on it and Staff 3 already administered Resident 41's liquid medication to Resident 49. Staff 4 stated Staff 3 was going to give additional medications and she stopped her as she recognized that Resident 49 did not get liquid medication and the incorrect resident's room number was on the medication cup. Staff 4 stated Staff 2 and Resident Care Managers were notified of the incident.On 4/8/26 at 12:09 PM, 4/8/26 at 12:45 PM and 4/10/26 at 10:20 AM Staff 2 stated Staff 3 refused to give a written statement regarding the medication error. Staff 2 stated Staff 3 worked with Resident 49 previously and a few weeks prior to the medication error she had a conversation with Staff 3 specifically because another staff reported they observed the resident having difficulty swallowing medication when Staff 3 administered medications to the resident. Staff 2 stated Staff 1 (Administrator) was present and they called Staff 3 in and reviewed Resident 49 in the electronic health record including her/his photo and specific orders to have medications crushed. Staff 2 stated on 11/3/25 Staff 3 administered Resident 41's methadone 40 mg to Resident 49 due to Staff 3 not confirming who the resident was prior to administering medication. Staff 2 stated the physician was notified and Resident 49 was sent to the hospital due to Staff 3 administering Resident 41's 40 mg of methadone to Resident 49 in error resulting in a change of condition.No evidence was found to indicate additional deficient practice occurred after 11/3/25. Due to the facility's identification of the deficient practice, and corrective measures put in place on 11/10/25, the deficient practice was determined to be past noncompliance.Refer to F760.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure a resident was free from a significant medication error for 1 of 1 sampled resident (#49) reviewed for significant medication error. Resident 49 required emergency treatment and was hospitalized for monitoring due to a methadone (narcotic pain medication) overdose. Findings include:Resident 49 admitted to the facility in 2021 with diagnoses including COPD and diabetes. The 11/3/25 8:37 AM signed medication error report written by Staff 3 (LPN) indicated the following: This LN [licensed nurse] asked CNA in dining room who room [Resident 41] was and when she pointed with her head it was towards [Resident 49], so this LN gave methadone to [Resident 49] instead of [Resident 41], no side effects noted at this time. Unclear which patient was pointed at, seemed like this patient's direction was pointed at. The note indicated the physician responded to monitor for somnolence for the rest of the day, and if noted, administer Narcan (opioid antagonist medication). The 11/3/25 11:10 AM progress note by Staff 2 (DNS) indicated the following: Called [physician] to report change in condition. Resident somnolent and with slurred speech. Taken back to room and developed nausea/vomiting. Awake and talking during episode. Alert and oriented self and place with history of dementia, unchanged level of orientation from baseline. Blood pressure 180/64, pulse 52, respirations 14, oxygen saturation 96% on room air. New orders to administer Narcan nasal spray 4 mg x 1, and Zofran [antiemetic medication] 4 mg po x 1. Call physician back if no improvement after Narcan administration. Resident was assisted into bed and closely monitored.The 11/3/25 11:40 AM progress note by Staff 2 indicated the following: Resident no longer with emesis, however, remains with GI upset and stating 'I don't feel good.' Heart rate 44 and irregular, pauses noted when listening to apical pulse. Heart rate 44, respirations 18, oxygen saturation 95% on room air. One liter oxygen per nasal canula placed and [the physician] called back .and ordered to transfer the resident to the emergency room for monitoring and evaluation.The 11/7/25 facility investigation indicated the following:-On 11/3/25 at approximately 8:30 AM a medication error occurred. Staff 3 administered Resident 41's methadone 40 mg to Resident 49. The provider was notified immediately, and Resident 49 was placed on close monitoring. -At approximately 11:00 AM Resident 49 exhibited a change in condition. Narcan and Zofran were administered per provider orders, and staff continued to monitor the resident closely. At 11:45 AM the provider was again contacted due to continued changes in condition and instructed staff to send the resident to the emergency room for hospital evaluation.-At 11:53 AM, 911 was called and Resident 49 was transferred to the hospital for evaluation and was subsequently admitted for further monitoring.-The licensed nurse responsible for the medication error was educated by Staff 2 on the five rights of medication administration, starting with their photo identification on record and verification of name. Staff 3 was subsequently placed on administrative leave pending investigation.-In conclusion, the investigation determined Staff 3 did not follow proper resident identification procedures and failed to confirm the resident's identity prior to medication administration.-Resident 49 readmitted to the facility on [DATE].The 11/7/25 hospital records indicated Resident 49 was hospitalized for a primary diagnosis of accidental methadone overdose and bradycardia (slow heart rate). The resident accidentally received 40 mg of liquid methadone that was meant for another resident. The emergency department called poison control who recommended 8-hour monitoring due to increases of arrhythmias, bradycardia, nausea and vomiting. After the eight hours, the resident continued to have intermittent bradycardia and atrial fibrillation and the resident was admitted for observation of unintentional methadone overdose. On 4/9/26 at 9:34 AM Staff 3 stated she remembered the incident when Resident 49 received Resident 41's methadone medication. She stated the resident was not in her/his room and she went to the dining room and asked CNA staff who Resident 49 was and they pointed her to the resident sitting up. Staff 3 stated she asked the resident if she/he was Resident 41's name and the resident stated Yes, yes, yes. She was unaware (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Resident 49 had confusion. Staff 3 stated she gave Resident 49 the liquid methadone medication and the nurse that was in the dining room told her that was not the correct resident and she did not administer additional medications to the resident. Staff 3 stated she then reported the medication error to the resident care managers. She stated she heard about the pulse being 44 and stated Staff 2 sent Resident 49 to the hospital.On 4/9/26 at 10:17 AM Staff 4 (LPN) stated on 11/3/25 she was in the dining room assisting a resident with a meal and heard Staff 3 say she could not crush medications, then observed Staff 3 next to Resident 49 with a medication cup with Resident 41's room number on it and Staff 3 already administered Resident 41's liquid medication to Resident 49. Staff 4 stated Staff 3 was going to give additional medications and she stopped her as she recognized that Resident 49 did not get liquid medication and the incorrect resident's room number was on the medication cup. Staff 4 stated Staff 2 and Resident Care Managers were notified of the incident.On 4/8/26 at 12:09 PM and 12:45 PM Staff 2 stated on 11/3/25 Staff 3 administered Resident 41's methadone 40 mg to Resident 49 due to the staff not confirming who the resident was prior to administering medication. Staff 2 stated Resident 49 was monitored and appeared to be sleepy and started throwing up so Staff 3 stayed in the room with the resident and CNAs. Staff 2 stated she obtained Narcan and Zofran, returned to the room and administered both medications to the resident. Staff 2 stated the physician was notified and Resident 49 was sent to the hospital due to Staff 3 administering Resident 41's 40 mg of methadone to Resident 49 in error resulting in a change of condition.On 4/10/26 at 10:20 AM Staff 1 (Administrator) stated education was completed for all nursing staff after the 11/3/25 medication error and all staff were in serviced by 11/10/25.No evidence was found to indicate additional deficient practice occurred after 11/3/25. Due to the facility's identification of the deficient practice, and corrective measures put in place on 11/10/25, the deficient practice was determined to be past noncompliance.