

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/30/2024
NAME OF PROVIDER OR SUPPLIER  Marquis Piedmont Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  319 NE Russet Portland, OR 97211	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38140</b></p> <p>Based on observation, interview and record review it was determined the facility failed to treat residents in a dignified manner for 1 of 3 residents reviewed for resident rights. This placed residents at risk for diminished quality of life. Findings include:</p> <p>This deficient practice was identified at past non-compliance in the area of 483.10 Resident Rights when the facility failed to provide an environment which promoted the maintenance of dignity and respect for residents' quality of life.</p> <p>On 2/20/24, the non-compliance was corrected when the facility completed a root cause analysis of the incident and determined Staff 19 treated residents in a manner which was undignified and disrespectful. The Plan of Correction included: 1. All staff were educated on resident rights, respect, dignity, abuse and neglect. 2. All staff completed written tests on their knowledge of resident rights from the education provided. 3. Dignity and respect audits were completed on residents. 4. The quality assurance committee reviewed audits and grievances with no further incidents. 5. Staff 19 no longer worked at the facility.</p> <p>Resident 18 admitted to the facility on [DATE] with diagnoses including diabetes (body does not produce insulin properly) and edema (fluid retention).</p> <p>Resident 18's 12/17/23 Quarterly MDS indicated a BIMS score of 15 (cognitively intact).</p> <p>Review of the 1/25/24 FRI revealed on 1/22/24 Resident 18 told Staff 20 (Social Services Director) about the night shift CNA, Staff 19 (Former CNA). Resident 18 stated she/he asked to be cleaned after a bowel movement and her/his assigned CNA, Staff 19, refused, and stated I'm not wiping your ass. Resident 18 then went to the charge nurse who also asked Staff 19 to provide care, Staff 19 still refused, stating that the resident could do it her/himself. The charge nurse switched CNA assignments and another CNA provided care to the resident shortly thereafter.</p> <p>On 9/25/24 at 3:05 PM Resident 18 confirmed the 1/22/24 incident with Staff 19. Resident 18 stated she/he did not feel abused but considered Staff 19's comment demeaning. Resident 18 stated she/he was provided care by other staff timely.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at 10:58 AM Staff 20 acknowledged Resident 18 told him about Staff 19's comment and refusal to provide care. Staff 20 completed resident interviews of other residents Staff 19 was assigned to care for and found two other residents who reported Staff 19 had an attitude problem and made inappropriate comments in the past.</p> <p>On 9/26/24 at 2:08 PM Staff 1 (Administrator) stated she expected all residents to be treated with dignity and respect. Staff 1 stated the facility completed an investigation and found Staff 19 made rude comments to Resident 18 and two other residents. Staff 1 stated Staff 20 completed audits for resident dignity and respect before each monthly Quality Assurance meeting.</p> <p>The facility's implementation of corrective actions was verified through the survey process. Observations conducted throughout the facility 9/24/24 through 9/30/24 revealed no concerns in which the staff treated residents with disrespect or a lack of dignity.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to ensure dependent residents received showers for 1 of 2 sampled residents (#17) reviewed for showers. This placed residents at risk for unmet needs and loss of dignity. Findings include:</p> <p>Resident 17 was admitted to the facility in 5/2024 with diagnoses including multiple sclerosis (a progressive neurological disorder) and morbid obesity (having a body mass index greater than 40).</p> <p>Resident 17's 9/6/24 Quarterly MDS indicated the resident had no cognitive impairment and was dependent for bathing/showering.</p> <p>The facility's 8/2024 shower schedule revealed Resident 17 was to receive showers twice a week, on Sundays and Thursdays.</p> <p>Resident 17's 8/2/24 through 8/31/24 bathing task logs indicated the resident received bathing on the following days:</p> <p>- 8/2, 8/9, 8/21, 8/28 and 8/31. Resident 17 received five out of nine scheduled showers.</p> <p>A review of Resident 17's Progress Notes from 8/1/24 through 8/31/24 revealed no documentation Resident 17 was provided with additional bathing opportunities when bathing was not provided.</p> <p>On 9/24/24 at 10:26 AM and 9/26/24 at 12:30 PM Resident 17 stated she/he was not showered and her/his hair was not washed for three weeks. Resident 17 reported she/he refused only one shower during the month of 8/2024, she/he was not provided with additional opportunities to shower and missed showers were not rescheduled.</p> <p>On 9/24/24 at 3:20 PM, 9/25/24 at 10:12 AM and 9/25/24 at 11:45 AM Staff 9 (CNA), Staff 10 (CNA) and Staff 14 (CNA) reported when showers were missed or refused, the resident's shower typically could not be rescheduled due to staffing issues.</p> <p>On 9/26/24 at 1:22 PM Staff 2 (DNS) reported there was a miscommunication regarding Resident 17's showers which resulted in missed showers. She stated her expectation was residents received a minimum of two showers a week, more if that was their preference. Staff 2 confirmed Resident 17 did not receive two showers each week during 8/2024.</p> <p>On 9/27/24 at 9:52 AM Staff 1 (Administrator) stated she expected nursing staff to document resident refusals in the resident's progress notes. Staff 1 stated residents should be offered the opportunity to reschedule their shower if the resident refused, was unavailable or missed a shower. Staff 1 confirmed there was no evidence Resident 17 was provided with additional showering opportunities if she/he refused or missed showers.</p> <p>Refer to F725.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>41458</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure there were sufficient nursing staff available to provide the necessary care and services to meet residents' needs in 1 of 1 facility reviewed for staffing. This placed residents at risk for unmet care needs. Findings include:</p> <p>On 9/24/24 the facility had a census of 51 residents. On 9/26/24, Staff 1 (Administrator) provided a list of residents who:</p> <ul style="list-style-type: none"> <li>-Required two-person mechanical lift transfers: 17;</li> <li>-Required two-person extensive or total assistance for bathing: 3;</li> <li>-Required two-person extensive or total assistance for toileting: 3;</li> <li>-Required two-person extensive or total assistance for dressing: 6;</li> <li>-Required one-to-one feeding: 3</li> <li>-Had behavioral health needs which required monitoring: 50;</li> <li>-Were high fall risks: 28;</li> <li>-Were considered at risk for elopement: 1 and</li> <li>-Required bariatric care (body mass index greater than 40): 6.</li> </ul> <p>On 8/26/24 a public complaint was received by the State Agency which alleged staff were not able to provide care such as showers and care was not timely due to low staffing.</p> <p>On 9/24/24 at 10:26 AM and 9/26/24 at 12:30 PM Resident 17 stated she/he was not showered and her/his hair was not washed for three weeks. Resident 17 stated there were not enough staff to assist her at times, especially during mealtime. Resident 17 reported she/he required two staff to assist her/him with most care and it could be difficult for staff to find a second person to help. Resident 17 stated on 9/25/24 at 5:00 PM, she/he activated her/his call light for assistance and was finally assisted at 8:00 PM because staff were assisting residents at dinner and two staff were not available, thus she/he waited three hours before receiving assistance.</p> <p>On 9/26/24 at 9:10 AM Resident 24 stated the facility was understaffed. Resident 24 stated when she/he needed assistance, sometimes it takes a long time. Resident 24 stated at times, staff did not show up so there were not enough staff to provide timely care. On 9/26/24 at 8:36 AM Resident 24's call light was activated for one hour and one minute.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 9/26/24 at 10:05 AM Resident 22 stated the facility was often short-staffed. Resident 22 stated at times, she/he had to go to the bathroom right away and staff were supposed to assist her/him to the bathroom but sometimes it took too long so she/he went to the bathroom without assistance.</p> <p>On 9/24/24 at 2:19 PM Staff 4 (CNA) stated when staff did not show up or called out, it made it difficult to get care done. Staff 4 stated when the facility was short-staffed, it was difficult to get vital signs and showers completed, toileting done and to get residents up. Staff 4 stated everything had to be done fast instead of moving at the rate residents preferred.</p> <p>On 9/25/24 at 10:12 AM Staff 10 (CNA) reported staffing levels did not meet patient care needs. Staff 10 stated, at times, showers had to be skipped and when residents were unavailable for a shower or refused showering then showers could not be rescheduled due to staffing issues. Staff 10 stated CNA staff were frequently late arriving for their shifts which pushed back everything and resulted in CNAs having to hit the floor running.</p> <p>On 9/25/24 at 11:45 AM Staff 14 (CNA) stated the facility needed more staff because it was difficult to give good care because there was not enough time to do what I need to do. Staff 14 stated if a resident required two person assistance, they often had to wait until a second person was available. Staff 14 stated there were not enough staff, especially at mealtimes and staff were unable to make-up showers if a resident was unavailable, missed or refused a shower.</p> <p>On 9/26/24 at 2:00 PM Staff 16 (Staffing Coordinator) stated she staffed CNAs according to the State's mandatory minimum staffing ratios and not to the acuity needs of the residents.</p> <p>On 9/27/24 at 9:52 AM Staff 1 (Administrator) confirmed staffing was based on the State's mandatory minimum staffing ratios and not the acuity needs of the residents. Staff 1 stated it was difficult to find enough staff and they had challenges with staff calling out and not showing up for assigned shifts.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>41458</p> <p>Based on interview and record review it was determined the facility failed to ensure the Direct Care Staff Daily Report (DCSDR) postings were thoroughly completed or accurately reflected the number of staff working and their hours worked for 37 of 37 days reviewed for sufficient staffing. This placed residents at risk for incorrect staffing information. Findings include:</p> <p>Review of the 8/18/24 through 9/24/24 DCSDRs indicated the staff postings were incomplete or inaccurate on all 37 days reviewed.</p> <p>On 9/25/24 at 8:24 AM Staff 2 (DNS) acknowledged the 8/18/24 through 9/24/24 DCSDRs were not accurately completed and did not include the hours staff members worked on all 37 days reviewed.</p>