

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 04/10/2026
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure medications and biologicals were secured for 2 of 3 medication carts and 2 of 3 treatment carts reviewed for safe medication storage. This placed residents at risk for unauthorized access to medications. Findings include: The facility's 5/2010 Security of Medication Cart Policy specified the following:</p> <ul style="list-style-type: none"> -The nurse must secure the medication cart during the medication hall to prevent unauthorized entry. -Medication carts must be securely locked at all times when out of the nurse's view. <p>1. On 4/6/26 at 12:02 PM a treatment cart was observed to be unlocked on the North Hall. The nurse was not in view of the cart. The treatment cart contained multiple drawers with resident care items, including insulin and insulin supplies, prescribed creams and lotions, wound care supplies, nebulizer medications and supplies, and shampoos and other treatment supplies.</p> <p>On 4/6/26 at 12:04 PM Staff 10 (LPN) confirmed the cart was unlocked and contained medications and treatment supplies.</p> <p>On 4/9/26 at 9:57 AM Staff 2 (DNS) stated it was her expectation all medication and treatment carts remain locked when not in use in accordance with the facility policy.</p> <p>2. On 4/8/26 at 9:46 AM a medication cart was observed to be unlocked on the North Hall. The CMA was not in view of the cart. The medication cart contained multiple drawers with medications, including eye drops, inhalers, nasal sprays, resident prescribed medications, over-the-counter medications, and overflow medications.</p> <p>On 4/8/26 at 9:51 AM Staff 11 (CMA) confirmed the cart was unlocked and contained resident medications.</p> <p>On 4/9/26 at 9:57 AM Staff 2 (DNS) stated it was her expectation all medication and treatment carts remain locked when not in use in accordance with the facility policy.</p> <p>3. On 4/10/26 at 9:18 AM a treatment cart was observed to be unlocked on the [NAME] Hall. The nurse was not in view of the cart. The treatment cart contained multiple drawers with resident care items, including insulin and insulin supplies, prescribed creams and lotions, wound care supplies, nebulizer medications and supplies, and shampoos and other treatment supplies. (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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/10/26 at 9:25 AM Staff 12 (LPN) confirmed the cart was unlocked and contained medications and treatment supplies.</p> <p>On 4/9/26 at 9:57 AM Staff 2 (DNS) stated it was her expectation all medication and treatment carts remain locked when not in use in accordance with the facility policy.</p> <p>4. On 4/8/26 at 2:20 PM an unlocked medication cart was observed to the right of the social services office and left of room [ROOM NUMBER]. No staff were observed in view of the unlocked medication cart.</p> <p>On 4/8/26 at 2:22 PM a CNA walked pass the unlocked medication cart.</p> <p>On 4/8/26 at 2:22 PM Staff 11 (CMA) returned to the unlocked medication cart. Staff 11 acknowledged she left the medication cart unattended and unlocked. Staff 11 confirmed it was expected for medication carts to always be locked when unattended. Staff 11 confirmed the medication cart contained resident medications, insulin supplies. eye drops, and inhalers.</p> <p>On 9/9/26 at 9:57 PM Staff 2 (DNS) stated it was the expectation all medication carts remain locked when not in use in accordance with the facility policy.</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, interview and record review it was determined the facility failed to assess residents for safe self-administration of medication for 1 of 2 sampled residents (# 29) reviewed for self-administering medication. This placed residents at risk for an unsafe medication regimen. Findings include: Resident 29 was admitted to the facility in 12/2025 with diagnoses including depression and end stage renal failure. Resident 29's 12/17/25 admission MDS assessed her/him as cognitively intact. On 4/6/26 at 11:47 AM and 1:19 PM observations were made of an empty six pack of Imodium on Resident 29's dresser to the right of her/his bed. On 4/6/26 at 2:34 PM observations were made of an empty six pack of Imodium on Resident 29's dresser to the right of her/his bed and a small clear plastic pill cup which contained two capsule pills and three small tablet pills on her/his window counter. On 4/7/26 at 1:50 PM observation was made of an empty six pack of Imodium on Resident 29's dresser to the right of her/his bed. On 4/8/26 at 8:39 AM three individual empty pill packs were observed on Resident 29's sink counter and one on floor by her/his bed. A review of Resident 29's medical records on 4/8/26 at 11:26 AM did not provide any indication she/he was safe to self-administer her/his own medications. On 4/8/26 at 1:00 PM Staff 11 (CMA) walked into Resident 29's room, left a white tablet pill in a small clear plastic pill cup with Resident 29 and left the room. On 4/8/26 at 1:00 PM Resident 29 stated staff leave this pill with her/him to take after meals and often leave other pills for her/him to take later if she/he does not want to take them at the time. On 4/8/26 at 2:24 PM Staff 11 stated some residents had medications left at the bedside to self-administer and the MAR indicated if a resident was able to take medication without staff supervision. Staff 11 looked at the computer and confirmed Resident 29 did not have directions to allow staff to leave medications at her/his bedside. On 4/8/26 at 2:39 PM Staff 15 (Resident Care Manager) stated staff were expected to not leave any medications in a resident's room unless the resident was assessed with a Self-Administration Assessment to ensure they were safe to take medication without supervision. Staff 15 stated she frequently removed medications from Resident 29's room and Resident 29 was known to obtained over the counter medications from the community. Staff 15 confirmed Resident 29 did not have a Self-Administration Assessment, and the resident should not have any medications in her/his room to self-administer. On 4/9/26 at 10:01 AM Staff 2 (DNS) acknowledged all residents who wished to self-administer medications were expected to be assessed for safety and no medication should not be left at bedside without an assessment.</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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, interview and record review the facility failed to protect the resident's right to be free from physical abuse for 1 of 1 (#11) sampled resident reviewed for abuse. This placed residents at risk for continued physical abuse. Findings include: Resident 11 was admitted to the facility in 2024 with diagnoses including dementia and hearing deficit. Resident 11's 10/9/25 Quarterly MDS assessed her/him as cognitively intact and received anticoagulant (blood thinner) medication daily. Resident 36 admitted to the facility in 11/2025 with diagnoses including diabetes and visual deficit. Resident 36's 11/30/25 admission MDS assessed her/him as cognitively intact. On 3/29/26 Staff 21 (LPN) initiated a Resident-to-Resident Event Assessment for an incident involving Resident 11 and Resident 36. The assessment revealed Resident 11 reported asking Resident 36 to turn down the television volume and was punched in the face on 3/29/26 at 7:50 PM, resulting in Resident 11 obtaining a bloody nose. Staff 21 cleaned up Resident 11's face, assessed her/him for injury and found no bruising or swelling. Staff 21 offered to move Resident 36 to another room and Resident 36 agreed. The Resident-to-Resident Event Assessment section completed by Staff 4 (RNCM) on 3/30/26 revealed on 3/29/26 Resident 11 entered Resident 36's room due to the television being loud. Resident 11 approached Resident 36 who was lying in bed and talking on her/his cell phone. Due to Resident 11's hearing impairment, she/he did not understand when Resident 36 told her/him to leave the room. The situation escalated and resulted in Resident 11 sustaining a bloody nose. Staff 4 assessed no long-term effects or physical harm. Progress notes from 3/30/26 through 4/1/26 revealed Resident 11 was placed on alert charting and assessed daily by Staff 14 (RN) and Staff 21. The resident had no injuries, bruising or swelling to the face/nose area. Resident denied any pain or discomfort to her/his face/nose area. The Resident-to-Resident Event Assessment revealed on 4/1/26 revealed the following: -Staff 5 (Social Services Director) met with Resident 11 regarding the interaction with Resident 36 on 3/29/26. Resident 11 told her the incident was a miscommunication between the two parties and stated no harm was intended by Resident 36. -Resident 11 stated the situation escalated due to a misunderstanding. Resident 11 would like to talk with Resident 36 in hope to clear things up and maybe become friends. -Resident 36 stated she/he was lying on her/his bed talking on her/his cell phone when Resident 11 came into her/his room. Resident 36 stated Resident 11 was yelling, demanded the television volume lowered and proceeded to grab her/his cell phone. Resident 36 stated she/he became upset and ended up hitting Resident 11 on the face with the phone. On 4/6/26 at 10:04 AM Resident 11 stated she/he felt safe in the facility and with other residents. Resident 11 indicated she/he recalled the 3/29/26 incident with Resident 36. Resident 11 stated although she/he was hard of hearing, loud televisions annoyed her/him. Resident 11 was observed with no signs of bruising to the face. On 4/9/26 at 12:31 PM Staff 4 stated she interviewed Resident 11 and Resident 36 after the 3/29/26 incident. Staff 4 stated Resident 36 had a history of verbal aggression and talked rough. When Staff 4 interviewed Resident 36 she asked her/him to demonstrate the action made when Resident 11 was hit. Staff 4 reported Resident 36 demonstrated a tap to the face with the flinch in attempt to keep Resident 11 from taking her/his phone and the contact was not intentional. Staff 4 stated Resident 36 seemed more annoyed than angry when interviewed. Staff 4 reported she assessed Resident 11 who sustained a bloody nose due to the tap to the nose and because of anticoagulant medication use. Staff 4 stated Resident 11 had a history of bruising easily, but no bruising was observed after the 3/29/26 incident. On 4/9/26 at 2:44 PM Resident 36 stated approximately one week earlier, Resident 11 came into her/his room yelling about the television volume down and attempted to grab her/his cell phone. Resident 36 stated she/he resisted and unintentionally struck Resident 11 in the face and had no intent to harm. Resident 36 stated she/he just wanted Resident 11 to leave her/his room. On 4/10/26 at 2:25 PM Resident 11 stated she/he had a bloody nose from a misunderstanding with Resident 36. Resident 11 stated (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>she/he was not hurt and just wanted to work it out with Resident 36 but she/he was not interested. On 4/10/26 at 11:30 AM Staff 1 (Administrator) acknowledged the facility expected all residents to be free from abuse. Staff 1 stated the facility immediately implemented interventions and corrective action was taken on 3/30/26 to ensure residents resident safety. Staff 1 concluded the incident was resident to resident abuse event and Resident 11 sustained a bloody nose due to Resident 36's flinch, which was not intentional. Staff 1 confirmed no resident-to-resident incidents had occurred since 3/30/36. The deficient practice was identified as Past Noncompliance based on the following:-On 3/30/26, the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the incident and there was a resident-to-resident abuse altercation: 1. Separated Residents 11 and 36 immediately and relocated Resident 36. 2. Initiated alert charting for both residents. Reviewed and updated both residents' care plans. 3. Completed audits for all residents with televisions and offered headphones for volume control. 4. Provided immediate staff education on 3/30/26 regarding signs of abuse, recognition of triggers, de-escalation techniques, and reporting requirements. 5. Continued ongoing review through the QAPI Committee regarding abuse protocols.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review it was determined the facility failed to provide notice of bed hold policies for 1 of 1 sampled resident (#4) reviewed for hospitalizations. This placed residents at risk for miscommunication of the discharge process. Findings include: Resident 4 was admitted to the facility in 2/2026 with diagnoses of congestive heart failure and epididymitis (inflammation of the tube at the back of the testicle). Resident 4's clinical record revealed the resident was transferred to the hospital on 4/3/26 for evaluation and treatment related to swelling of the scrotum. The resident's provider was notified, and orders were received to send Resident 4 to the hospital for further evaluation. Resident 4's clinical record did not contain documentation to indicate a written notice of the facility's bed hold policy was provided to Resident 4 or her/his representative. On 4/10/26 at 11:30 AM, Staff 2 (DNS) stated the charge nurse was responsible for providing the bed hold policy to residents when they were sent to the hospital. Staff 2 stated there was no documentation Resident 4 received a bed hold notice and it was her expectation the form was completed at the time of transfer. On 4/10/26 at 11:40 AM Staff 1 (Administrator) confirmed a bed hold policy was not completed for Resident 4 at the time of transfer.</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>Based on observation, interview and record review the facility failed to ensure nail care was provided for 1 of 5 sampled residents (#29) reviewed for ADLs. This placed residents at risk for unkept hygiene needs. Findings include: Resident 29 admitted to the facility in 12/2025 with diagnoses including diabetes and end stage renal failure. Resident 29's 12/17/25 admission MDS assessed her/him as cognitively intact. On 4/6/26 at 11:47 AM Resident 29 was observed with long pointed fingernails with dark substance under the nails. Resident 29 stated she/he required assistance to trim her/his fingernails due to her/his diabetes diagnosis. Resident 29 stated she/he would like her/his nails trimmed and had not been offered assistance. Record review of Resident 29's health record revealed no directions for staff to assist or offer to trim her/his fingernails and no documentation the fingernails had been completed. On 4/8/26 at 2:27 PM Staff 13 (CNA) stated he did not trim resident's fingernails if the resident was diabetic and only licensed nurses completed the task. On 4/8/26 at 2:29 PM Staff 14 (RN) stated residents who have a diabetic diagnosis could not trim their own fingernails in the facility and only a licensed nurse could trim the fingernails for health and safety reasons. On 4/8/26 at 2:39 PM, Staff 15 (Resident Care Manager) stated only a licensed nurse could trim Resident 29's fingernails and it was expected the plan of care would direct a licensed nurse to perform the task. Staff 15 reviewed Resident 29's health record and confirmed the resident did not have any plan directing a licensed nurse to assist the resident's fingernail trimming, nor any documentation indicating a nail trim was completed. On 4/9/26 at 10:01 AM Staff 2 (DNS) acknowledged it was the expectation for Resident 29 to have a plan of care to direct licensed nurses to trim her/his fingernails.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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>Based on observation, interview and record review it was determined the facility failed to provide care planned safety interventions for 1 of 7 sampled residents (#25) reviewed for accidents. This placed residents at risk for falls and injury. Findings include: Resident 25 was admitted to the facility in 8/2024 with diagnoses of dementia and anxiety disorder. A 3/16/26 Quarterly MDS revealed Resident 25 had a BIMS of 14, which indicated she/he was cognitively intact. A 3/27/26 fall care plan revealed Resident 25 was at high risk for falls due to acute medical conditions, stroke and history of falls. Fall preventions included no assistive devices at bedside, bed in lowest position and fall mat at bedside. Random observations from 4/6/26 through 4/9/26 from 8:00 AM to 4:00 PM revealed Resident 25 was observed in bed with her/his walker at bedside and within reach, the bed was not in the lowest position (approximately knee height), and no fall mat was in place. On 4/9/26 at 10:18 AM, Staff 17 (CNA) stated Resident 25 was a high fall risk and was to have no assistive devices at bedside, bed in the lowest position and a fall mat in place. Staff 17 entered the room, observed Resident 25 in bed, and confirmed her/his walker was within reach, the bed was not in the lowest position, and a fall mat was not in place. On 4/9/26 at 10:25 AM, Staff 16 (RN) stated Resident 25 was to have no assistive devices within reach, bed in the lowest position and a fall mat in place. Staff 16 entered the room, observed Resident 25 in bed, and confirmed her/his walker was within reach, the bed was not in the lowest position, and a fall mat was not in place. On 4/9/26 at 10:32 AM, Staff 4 (RNCM) confirmed Resident 25 was care planned to have no assistive devices within reach, her/his bed in the lowest position, and a fall mat at bedside. On 4/9/26 at 12:32 PM, Staff 2 (DNS) stated it was her expectation that staff follow and implement all care planned fall interventions.</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to identify PTSD (Post Traumatic Stress Disorder) triggers, provide treatment and services to address distress related to PTSD for 1 of 1 sampled resident (#5) reviewed for behavior health. This placed residents at risk for unrecognized triggers and increased or worsening PTSD related symptoms. Findings include: A 5/2019 Trauma Informed Care Policy indicated staff completed assessments to gather how trauma impacts the residents care needs in triggers, approaches and person-centered care planning, duration and frequency of problematic behaviors or changes in behavior, cognition, or mood. Resident 5 was admitted to the facility on [DATE] with diagnoses including PTSD. A 3/23/26 admission MDS indicated Resident 5 had a BIMS score of 15 indicating the resident was cognitively intact. The Mood and Behavior CAA indicated the resident's psychosocial well-being would be addressed in her/his care plan with a goal of maintaining current level of functioning and to avoid complications. A 3/18/26 Care Plan did not address Resident 5's PTSD triggers or interventions. The Care Plan indicated the resident did not want to talk about PTSD diagnoses and she/he refused counseling services. A 3/18/26 Social Services admission form indicated Resident 5 scored a 15 out of 27 on the PHQ-2 to 9 assessment indicating moderate depression. The social services form did not address the residents PTSD diagnosis, triggers or interventions. Progress notes dated 3/22/26 at 12:56 PM, 3/23/26 at 12:02 PM and 3/27/26 at 5:37 PM indicated Resident 5 was distressed, had increased symptoms of anxiety and expressed mental health concerns. The resident requested to check in with Staff 5 (Social Services). A 3/24/26 Care Conference did not address Resident 5's PTSD diagnosis, triggers or interventions. A review of Resident 5's clinical record revealed no evidence the resident refused to discuss her/his PTSD diagnosis and no follow-up was completed with Staff 5. On 4/6/26 at 12:06 PM and 4/8/26 at 10:45 AM, Resident 5 stated staff did not address her/his PTSD diagnoses, triggers and interventions. Resident 5 stated staff offered counseling services upon admission, but staff did not follow up. Resident 5 stated she/he experienced childhood trauma including abandonment, sex trafficking, substance abuse, sexual and physical abuse. Resident 5 stated she/he was triggered by closed doors, windows, curtains, opened bathroom doors, perfumes, supplies with high alcoholic content, chicken pot pies and [NAME] tea. Resident 5 stated when doors were closed, she/he felt isolated, trapped and scared. Resident 5 stated prolonged exposure to PTSD related triggers increased anxiety and required medications to decrease symptoms. Resident 5 stated during a recent facility fire drill, staff closed the door, which resulted in her/him experiencing increased anxiety and isolation. Resident 5 stated the door remained closed until the fire drill ended and the resident was distressed for a couple of hours after the fire drill. An observation on 4/8/26 at 11:24 AM to 11:31 AM, Staff 7 (CNA) entered Resident 5's room and assisted her/him to the bedside commode. Staff 5 walked by and attempted to close the door. Resident 5 stated, Having the door and curtain opened for care is my preference. Staff 5 did not respond and she walked away. On 4/8/26 at 2:56 PM, Staff 22 (CNA) stated Resident 5 experienced claustrophobia and preferred to have the window open and the blinds up. Staff 22 stated Resident 5 was sensitive to scents but was unsure which scents caused distress. Staff 22 stated she was unaware Resident 5 had a PTSD diagnosis. Staff 22 stated Resident 5 was anxious when staff did not perform care in a manner the resident preferred. On 4/8/26 at 12:06 PM, Staff 7 stated she was unaware Resident 5 had a PTSD diagnosis and would refer to the care plan. Staff 7 stated Resident 5 was triggered by closed doors and hand sanitizer which caused her/him to become anxious. On 4/8/26 at 3:03 PM, Staff 5 stated she had not talked to Resident 5 about her/his PTSD diagnosis and had not addressed any triggers or interventions. Staff 5 stated she was unaware whether Resident 5 had any PTSD related triggers. She stated she had asked the (continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident upon admission if she/he wanted counseling services, but the resident refused, and she did not follow up. Staff 5 stated she did not complete a behavior assessment related to Resident 5's PTSD diagnosis. On 4/8/26 at 3:17 PM, Staff 20 (RN) stated she was unaware of Resident 5's PTSD diagnosis. She reported Resident 5 became triggered when staff closed her/his bedroom door and the resident was triggered when the fire alarm sounded, at which time the resident refused to close her/his bedroom door. Staff 20 stated the resident experienced panic attacks when triggered. She stated Resident 5's PTSD triggers and related interventions were not included in the resident's care plan and the resident had not received services related to PTSD. On 4/9/26 at 1:05 PM, Staff 4 (RNCM) stated she was aware Resident 5 had a PTSD diagnosis, but she did not address Resident 5's PTSD diagnosis, identify triggers or develop interventions. Staff 5 stated she avoided discussing PTSD because she believed mentioning the trauma could worsen the resident's anxiety. Staff 4 stated she focused on the resident's physical health versus mental health. On 4/10/26 at 9:20 AM, Staff 2 (DNS) stated she was aware of Resident 5's diagnosis of PTSD. Staff 2 stated staff did not re-approach the resident after she/he admitted and did not offer counseling services. Staff 2 stated she did not specially address the resident's PTSD because Resident 5's other mental health diagnoses overlapped. Staff 2 stated she was aware about Resident 5's preference to use the commode with the door open and staff were accommodating and left the door open. Staff 2 acknowledged Resident 5 did not receive counseling services or have a care plan addressing her/his PTSD diagnosis, associated triggers or interventions.</p>		

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 04/10/2026
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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide dental services for 1 of 2 sampled residents (#9) reviewed for dental care needs. This placed residents at risk for inadequate provision of dental services. Findings include: Resident 9 was admitted to the facility in 3/2026 with diagnoses including end stage renal disease and type 2 diabetes. Resident 9's admission MDS dated [DATE] revealed she/he was cognitively intact and had no missing, cracked or decayed teeth. Resident 9's 3/12/26 Nursing admission Assessment indicated she/he had, no dental issues. Resident 9's care plan dated 3/16/26 indicated she/he required constant supervision and physical assistance to complete oral hygiene tasks. On 4/6/26 at 2:33 PM, Resident 9 was observed to have several broken and missing upper front teeth. Resident 9 stated she/he was missing most of her/his upper teeth and had cavities which made it challenging and sometimes painful to chew. Resident 9 stated staff never examined the inside of her/his mouth and did not ask about her/his dental health. On 4/8/26 at 3:09 PM Staff 18 (CNA) stated she did not assist Resident 9 with oral care but just reminded the resident to brush her/his teeth after meals. On 4/8/26 at 4:02 PM Staff 19 (CNA) stated she thought Resident 9 was independent to complete oral hygiene and she only reminded her/him to brush her/his teeth after meals. On 4/8/26 at 4:17 PM Staff 20 (LPN) stated CNAs assisted Resident 9 to brush her/his teeth after meals and she did not know if the resident had cavities or missing teeth. On 4/10/26 at 12:53 PM Staff 12 (LPN) stated Resident 9 was fairly independent and required set up assistance for oral care. Staff 12 stated she never assessed Resident 9's teeth and was not aware if she/he had missing teeth or cavities. On 4/10/26 at 2:29 PM Staff 2 (DNS) examined Resident 9's dentition and stated she/he had missing, cracked and decayed teeth which needed to be addressed. Staff 2 stated she expected dental health assessments to be complete and accurate so residents will receive the dental care they require.</p>