STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Marquis Mill Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1475 SE 100th Avenue Portland, OR 97216	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47000 Based on observation, interview and record review it was determined the facility failed to accurately code the MDS for 2 of 2 sampled residents (#s 6 and 65) reviewed for dental care and hospitalization s. This placed residents at risk for unmet care needs. Findings include: 1. The facility's 8/2017 Resident Assessment Instrument MDS 3.0 Policy indicated information derived from the comprehensive assessment enabled staff to plan care to allow the resident to reach her/his highest practicable level of functioning and included an assessment of the resident's dental status and the need for, and use of, dentures or other dental appliances. Resident 6 was admitted to the facility in 8/2024 with diagnoses including kidney failure. Resident 6's 8/5/24 Nursing Admission Assessment indicated the resident had a full upper and lower set of dentures. Resident 6's 8/11/24 Admission MDS revealed the resident was cognitively intact and not edentulous (without teeth). Resident 6's 8/24/24 Dental Care Plan indicated the resident had her/his natural teeth. On 1/27/25 at 12:07 PM Resident 6 was observed in her/his room and sat in her/his wheelchair. Resident 6 was observed to be edentulous, and the resident stated she/he was without teeth for over a decade. On 1/29/25 at 3:44 PM Staff 11 (RNCM) stated Resident 6's Admission MDS was coded in error as the resident admitted to the facility without teeth. On 1/30/25 at 12:33 PM Staff 2 (DNS) confirmed Resident 6's 8/11/24 Admission MDS was coded inaccurately. 39632 2. Resident 65 was admitted to the facility in 11/2024 with diagnoses including UTI. Resident 65's 12/20/24 Discharge Return Not Anticipated MDS coded the resident as hospitalized . (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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	385214	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Mill Park	1475 SE 100th Avenue Portland, OR 97216

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 65's 12/20/24 Discharge Progress Note indicated the resident discharged home. On 1/31/25 at 3:08 PM Staff 2 (DNS) reviewed Resident 65's health record and confirmed the resident discharged home on 12/20/24. Staff 2 acknowledged the 12/20/24 Discharge MDS was incorrectly coded as hospitalized and did not accurately reflect the resident's discharge location.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 50928 Based on observation, interview and record review it was determined the facility failed to develop and implement a care plan related to the use of hearing aids for 1 of 1 sampled resident (#269) reviewed for hearing. This placed residents at risk for communication barriers and impaired hearing. Findings include: Resident 269 was admitted to the facility in 1/2025 with diagnoses including respiratory failure. In an interview on 1/27/25 at 10:26 AM, Witness 2 (Family Member) stated Resident 269 wore hearing aids during the day and needed assistance to charge them at night. Witness 2 stated when she/he visited the resident every morning the resident's hearing aids were still in her/his ears and were not charged. A review of Resident 269's care plan revealed no information related to use of hearing aids. On 1/28/25 at 8:43 AM, Resident 269 was observed sitting on her/his bed with one hearing aid in her/his left ear. The other hearing aid was in a charging device, located on the resident's nightstand. During an observation and interview with Resident 269 and Witness 2 on 1/29/25 at 10:21 AM, the resident's hearing aids were on the charging station blinking green. Witness 2 stated when she arrived the hearing aids were still in the resident's ears, and Witness 2 removed the hearing aids and placed them in the charging station. Witness 2 stated when the green light was blinking it indicated the hearing aids were not charged. On 1/29/25 at 11:29 AM, Staff 29 (CNA) and Staff 7 (LPN) were present for an interview. Staff 29 stated she provided care for Resident 296's hearing aids based upon what instructions were indicated in the resident's care plan. Staff 7 reviewed the resident's care plan and found no information related to the resident's hearing aids. On 1/30/25 at 12:35 PM, Staff 2 (DNS) confirmed the care plan lacked information related to the resident's use of hearing aids.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 47000 Based on observation, interview and record review it was determined the facility failed to provide appropriate foot care for 1 of 1 sampled resident (#6) reviewed for skin conditions. This placed residents at risk for lack of nail care and increased infections. Findings include: Resident 6 was admitted to the facility in 8/2024 with diagnoses including diabetes. Resident 6's 8/11/24 Admission MDS revealed the resident was cognitively intact. Resident 6's 10/29/24 Physician Orders indicated the resident was to be seen by a podiatrist for onychomycosis (a fungal infection of the nails) and diabetic foot care. An 11/19/24 Social Services Note revealed a message was left with the podiatrist to get follow up regarding the scheduling of Resident 6's podiatry appointment. A 1/8/25 Physician Encounter Note completed by Staff 13 (Medical Director) indicated the resident had a referral to be seen by a podiatrist from 10/29/24. No evidence was found in Resident 6's clinical record to indicate additional efforts to schedule a podiatry appointment for the resident were made after 11/19/24. On 1/29/25 at 12:54 PM Resident 6 was observed in her/his room. Resident 6 stated she/he had a wound on her/his right foot but was unsure if she/he needed to see a podiatrist. On 1/29/25 at 3:28 PM Staff 5 (Social Services Director) stated the last time she tried to schedule a podiatry appointment for Resident 6 was on 11/19/24. On 1/29/25 at 3:44 PM Staff 11 (RNCM) stated there was no follow up since November regarding the scheduling of Resident 6's podiatry appointment, and she recently spoke with Staff 14 (NP) who indicated she still wanted the resident to be seen by a podiatrist.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 47000 Based on observation, interview and record review it was determined the facility failed to ensure a resident who was a trauma survivor received trauma-informed care for 1 of 1 sampled resident (#6) reviewed for PASARR (Pre-Admission Screening and Resident Review). This placed residents at risk for re-traumatization and a decrease in their quality of life. Findings include: The facility's 5/2023 Trauma Informed Care Policy indicated the following: -Nursing staff, Social Services and the attending physician were to identify individuals with a history of trauma, as the resident was willing to disclose, as part of an initial assessment. Information could also be gathered from family and friends in order to identify and implement person-centered trauma-informed care. -Areas of potential life trauma were to be identified and developed into a person-centered care plan based on the Social Services Admission Assessment. This Assessment was to gather how trauma impacted the resident's care needs and triggers in addition to the resident's treatment history and/or a specialist that may have been involved in the care/support of the resident's trauma needs/PTSD (Post-traumatic stress disorder). -If the resident was treated for past trauma, facility staff and the provider would obtain and document ongoing reassessments of changes in the individual's behavior, mood and function no less than quarterly. -Staff were to document via Quarterly Social Services Assessment and/or in the MDS CAA interventions attempted and outcomes associated with person-centered trauma-informed interventions. Admission records received by the facility on 7/29/24, prior to Resident 6's admission to the facility, revealed the resident had an active diagnosis of PTSD. Resident 6 was admitted to the facility in 8/2024 with diagnoses including bipolar disorder (a chronic mental health condition characterized by extreme mood swings and caused by a complex interplay of multiple factors, including genetics, brain chemistry, psychological factors, other medical conditions and environmental factors such as trauma) and PTSD. Resident 6's 8/5/24 Social Services Admission Assessment revealed the resident chose not to share when asked if she/he experienced any traumas, such as war. Resident 6's 8/11/24 Admission MDS revealed the resident was cognitively intact. No evidence was found in Resident 6's clinical record to indicate staff were aware of the resident's diagnosis of PTSD or attempted to follow-up with the resident, the resident's family members, or medical providers, related to the resident's diagnosis of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 11:31 AM Resident 6 was observed in her/his room. Resident 6 tearfully recounted times when she/he witnessed and experienced extreme violence, and indicated facility staff did not ask about her/his history of trauma. On 1/29/25 at 12:54 PM Resident 6 was observed in her/his room and described her/his current leg infection to the state surveyor. Unprompted by the state surveyor, Resident 6 changed the conversation to the topic of the extreme violence she/he witnessed and experienced in the past. On 1/29/25 at 1:11 PM Staff 21 (CNA) stated Resident 6 had bad days when she/he got sad. Staff 21 was unaware of any potential trauma triggers for the resident. On 1/29/25 at 1:36 PM Staff 22 (CNA) did not express awareness of Resident 6's history of trauma. On 1/30/25 at 10:52 AM Staff 5 (Social Services Director), Staff 4 (Social Services Director) and Staff 11 (RNCM) were present for an interview. Staff 5, Staff 4 and Staff 11 stated they were unaware of Resident 6's diagnosis of PTSD and did not reapproach the resident about her/his history of trauma following her/his admission to the facility or reach out to family, friends or providers for additional information about the resident's PTSD and potential trauma triggers. On 1/30/25 at 12:46 PM Staff 2 (DNS) stated residents with a diagnosis of PTSD were to have a related care plan and staff were to reach out to family members when residents declined to discuss their trauma.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 47000 Based on observation, interview and record review it was determined the facility failed to provide treatment and services to correct ongoing signs of depressive behavior for 1 of 1 sampled resident (#49) reviewed for behavioral-emotional needs. This placed residents at risk for unmet behavioral and emotional needs and a decrease in their quality of life. Findings include: The facility's undated Behavioral Assessment for Un-Met Needs/Psychoactive Medications Policy indicated the following: -A Behavior UDA (assessment) was to be opened by the Social Services Director at the time a new behavior was noted and completed by the interdisciplinary team to ensure environmental/facility practices or medical/clinical causes of behavior, non-pharmacological interventions implemented and delirium were ruled out before the initiation of a medication/increased dosing. -If the physician/NP initiated a psychoactive medication, the RNCM was to follow up with the prescriber regarding the continued use of the medication. If the medication was not discontinued, the Social Services Director was to open a Behavior UDA within 72 hours of the medication start date. -If a resident had active behaviors upon admission, the Behavior UDA was to be completed by day 14 with the MDS. Resident 49 was admitted to the facility in 12/2024 with diagnoses including orthopedic aftercare following a surgical amputation and adjustment disorder (a mental health condition that develops as an unhealthy response to a stressful life event) with anxiety and depressed mood. Resident 49's 12/13/24 Social Services Admission Assessment indicated the loss of the resident's leg had her/him feeling down. A 12/17/24 Encounter Note written by Staff 14 (NP) revealed Resident 49 admitted to the facility following a hemipelvectomy (a surgical procedure that involved the removal of half of the pelvis bone and the lower extremity on that side). The note further revealed the resident experienced an increase in irritability, nervousness, anxiety, agitation and depressive mood as well as a lack of motivation in response to her/his amputation. She/he declined treatment with an antidepressant and had lorazepam (a medication used to treat anxiety and sleeping problems related to anxiety) available PRN. Resident 49's 1/10/25 Admission MDS revealed the resident was cognitively intact and felt down, depressed or hopeless several days over the previous two weeks. No evidence was found in Resident 49's clinical record to indicate any behavioral health services were offered, an individualized care plan was developed or ongoing monitoring of the resident's mood was completed in order to ensure her/his emotional and psychosocial needs were addressed and met. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/25 at 4:52 PM Resident 49 was observed in her/his room accompanied by Witness 1 (Family Member). Resident 49 stated she/he was more depressed now than [she/he] had ever been on account of her/his recent amputation. Resident 49 stated she/he was open to any kind of non-pharmacological psychosocial intervention, including counseling, but no one at the facility offered any psychosocial support. Witness 1 stated there was no mood support in the facility which did not make sense with residents like [Resident 49] coping with traumatic losses. On 1/29/25 at 1:11 PM Staff 21 (CNA) stated Resident 49 seemed sad and depressed at times but was not sure why or what to do about it. On 1/30/25 at 10:38 AM Staff 4 (Social Services Director) stated Resident 49 was depressed since she/he had her/his leg amputated. Staff 4 stated the resident coped with multiple losses and did not recall if she offered any psychosocial supports to the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39632 Based on observation, interview and record review it was determined the facility failed to ensure a medication administration error rate of less than 5%. There were two errors in 29 opportunities resulting in a 6.9% error rate. This placed residents at risk for reduced medication efficacy and adverse medication side effects. Findings include: The 2023 insulin lispro Kwikpen Manufacturer Instructions For Use and the 2022 How to Use Lantus Pen Manufacturer Instructions specified the following: - to prime pen, turn the Dose Knob to select two units. Hold the pen with the needles pointing up, tap the pen gently to collect air bubbles at the top, continue holding pen with needle pointing up, push the Dose Knob in until it stops and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. Turn the Dose Knob to select the number of units needed. Always perform these safety steps before each injection. Resident 118 was admitted to the facility in 1/2025 with diagnoses including type 2 diabetes mellitus (impaired insulin production). Resident 118's 1/2025 Physician Orders included the following: - Insulin lispro injection solution, inject six units subcutaneously with meals; - Insulin glargine solution pen-injector, inject seven units subcutaneously in the morning. On 1/29/25 at 8:40 AM Staff 6 (LPN) was observed during Resident 118's medication administration. Staff 6 obtained Resident 118's insulin lispro Kwikpen (insulin pen) and dialed the dose knob until six units was observed in the dose window . Staff 6 did not perform the safety steps as indicated in the manufacturer's instructions. Staff 6 obtained Resident 118's Lantus insulin glargine Kwikpen (insulin pen) and dialed the dose knob until seven units was observed in the dose window. Staff 6 did not perform the safety steps as indicated in the manufacturer's instructions. Staff 6 gathered the Kwikpens and administered the insulin to the Resident. On 1/29/25 at 9:11 AM Staff 6 stated he was unaware if preparation of insulin Kwikpens included the safety steps for priming. Staff 6 acknowledged he did not perform the safety steps prior to administration of Resident 118's insulin. On 1/29/25 at 11:33 AM Staff 2 (DNS) was notified Resident 118's insulin Kwikpens were not primed and the safety steps were not followed prior to administration. Staff 2 stated she expected staff to follow the safety steps for priming prior to insulin Kwikpen administration.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39632 Based on observation, interview and record review it was determined the facility failed to follow appropriate infection control practices during a COVID-19 outbreak for 2 of 4 halls reviewed for infection control. This deficient practice was determined to be an immediate jeopardy situation and placed residents at risk for contracting COVID-19. Findings include: The CDC's 3/6/24 Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings website, https://www.cdc.gov/infection-control/hcp/viral-respiratory-prevention/index.html, specified health care personnel are advised to apply appropriate Transmission-Based Precautions when providing care to a patient with known or suspected respiratory infection. Infection prevention and control practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection included to use Droplet Precautions with patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing or talking. Use an approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection worn during all patient care encounters. Remove face protection before room exit. The CDC's 9/2024 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings website, https://www.cdc.gov/infection-control/hcp/isolation-precautions/index.html, and the facility's 3/2024 Policy for Isolation - Categories of Transmission Based Precautions specified in all healthcare settings, providing patients who are on Transmission-Based Precautions with dedicated noncritical medical equipment (e.g., stethoscope, blood pressure cuff, electronic thermometer) has been beneficial for preventing transmission. When this is not possible, adequately clean and disinfect the items after each use and before use for another resident. On 1/27/25 and 1/28/25 between the hours of 6:59 AM and 4:24 PM the following observations and interviews occurred: - Rooms 302, 305, 307, 312, 315, 404, 405, 413, 414 and 417 were identified as Transmission Based Precautions (TBP) rooms where COVID-19 positive residents resided. - Staff 20 (CNA) exited room [ROOM NUMBER] with a respirator on her face and goggles on top of her head. Staff 20 removed the goggles with bare hands, placed the goggles in a pocket, removed the respirator and crinkled it into her hand, obtained a new respirator from a package of unused respirators while holding the contaminated respirator in the same hand, and donned the clean respirator. Staff 20 did not perform hand hygiene during the process. - While preparing to enter room [ROOM NUMBER], Staff 23 (LPN) donned a gown and gloves and did not don a new respirator and did not don eye protection. Staff 23 entered room [ROOM NUMBER] and provided close-contact direct care. Staff 23 exited the room, doffed the gown and gloves and did not doff the respirator. Staff 23 stated she was unsure if she needed eye protection during care for a resident known to be infected with COVID-19. Staff 23 stated she did not believe she needed to remove the respirator upon exit of a TBP room and stated the mask needed to be changed only when visibly soiled. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Staff 23 entered room [ROOM NUMBER] with gown, gloves, respirator and face shield. Upon exit, Staff 23 held the used face shield in her bare hands, did not remove or change the respirator and walked down the hall to the treatment cart. Staff placed the used face shield on the treatment cart without a barrier and did not disinfect the shield. Without changing the respirator used in room [ROOM NUMBER], Staff 23 entered room [ROOM NUMBER], a non-COVID-19 room, and provided close contact care. - Staff 24 (CNA) approached room [ROOM NUMBER] with a respirator and eye glasses donned. Staff 24 donned a gown and gloves and picked up a clear plastic bag from the floor which contained a blood pressure cuff, stethoscope, thermometer and oximeter (used to measure blood oxygen levels). Staff 24 entered room [ROOM NUMBER], removed the vitals equipment from the bag and placed the pieces directly on the resident's bed. Staff 24 obtained the resident's vital signs using the various pieces of equipment, placed the thermometer, oximeter and cuff back into the bag and placed the stethoscope around her neck. Staff 24 did not disinfect the equipment at any time during the process. Staff 24 exited the room after doffing the gown and gloves, did not remove the N95 or eye glasses and had the stethoscope draped around her neck. Staff 24 walked down the hall to the nursing station, placed the bag of vitals equipment directly on the counter, donned gloves and wiped the oximeter and thermometer with an alcohol prep pad. Staff 24 did not remove and disinfect the stethoscope and did not change the respirator. Staff 24 stated she did not remove the glasses between resident cares and left them on throughout the entire shift. Staff 24 stated she used the same vitals equipment for all of the residents on the 400 hall, including those residents not infected with COVID-19. - Staff 25 (RN) doffed his respirator, did not perform hand hygiene, donned a new respirator, did not don eye protection and then entered room [ROOM NUMBER]. Staff 25 stated he forgot to don eye protection and stated when he wore eye protection, he used the face shield which hung on the treatment cart in the hallway. - Staff 22 (CNA) stated she thought it was okay to store the used face shields in the PPE storage containers which hung on the room door and the face shields were shared with other staff. - Staff 9 (CNA) exited room [ROOM NUMBER], doffed the face shield and placed the used face shield inside the storage container with clean, unused PPE. Staff 9 stated she left the respirator on upon exit and stated she wore the same respirator in and out of resident rooms and at the nursing station. - Staff 26 (Physical Therapy Assistant) entered room [ROOM NUMBER], wore a respirator and did not don a gown, gloves or face shield. Staff 26 stated he was supposed to don PPE before entering but did not because he checked on the resident real quick. Staff 26 did not doff the respirator upon exit and continued to wear the same respirator throughout the hall. - Staff 27 (Physical Therapist) exited room [ROOM NUMBER] with a respirator and face shield donned. Staff 27 walked to a treatment cart at the end of the hall, donned gloves, removed the face shield, cleaned the shield with a disinfectant wipe, doffed the gloves, performed hand hygiene, tucked the used face shield between her side and arm and walked down the hallway. - Used face shields were stored on name placards outside of TBP rooms. - Used face shields were stored inside PPE storage containers, in contact with clean, unused PPE. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Used face shields were stored on medication and treatment carts in the 200, 300 and 400 hallways. On 1/28/25 at 8:29 AM and 9:55 AM Staff 2 (DNS) and Staff 3 (DNS in training) stated if a resident room was identified on TBP for COVID-19, staff were expected to don the required PPE before crossing through the doorway of the room. Staff 2 and 3 stated appropriate PPE included a gown, gloves, respirator and face shield which should be donned prior to entrance and doffed upon exit. Staff 2 and 3 indicated all PPE worn in a TBP room was considered contaminated and was to be discarded upon exit. Staff 2 and 3 stated they expected staff to don a new respirator right away and the same respirator was not worn in other rooms. Staff 2 indicated there was an abundance of face shields readily accessible and available and goggles were not an acceptable form of eye protection in a TBP room. Staff 2 stated she expected face shields were not shared between staff or used between resident care. She stated if face shields were reused by a single staff, she expected staff to disinfect the shield with the appropriate disinfectant between uses and store the used face shield in the PPE container. Staff 2 stated each TBP room was supplied with a dedicated stethoscope stored inside the room and was used on that resident only. She indicated if resident care equipment was shared among residents, the expectation included the equipment was disinfected with the appropriate product between every resident. Staff 2 acknowledged there was a risk of contamination and spread of infection if staff did not remove potentially contaminated PPE after resident care in a TBP room. Staff 2 stated the facility's first case of COVID-19 was identified on 1/9/25. On 1/28/25 at 12:00 PM Staff 1 (Administrator), Staff 2, Staff 3 and Staff 28 (Administrator in training) were informed the facility's failure to implement appropriate infection control during a COVID-19 outbreak constituted an Immediate Jeopardy situation. An IJ removal plan was requested. On 1/28/25 at 3:21 PM an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions: 1. Immediate staff training was initiated by the DNS and Administrator on COVID transmission protocols, proper use of PPE (donning, doffing and reuse), storage and handling of PPE, disinfecting and use of equipment. 2. Staff who received training included CNAs, nurses, housekeeping, laundry, maintenance, administrative staff, agency staff and contracted staff. 3. Staff training was done immediately for all staff in the facility then at each shift change on 1/28/25. 4. Documentation of training would include a sign in sheet and a PPE competency validation form. 5. Continued training would be conducted at each shift change and/or 1:1 until all staff received training. 6. For staff who were on leave, training would be provided prior to returning to work. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Marquis Mill Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1475 SE 100th Avenue Portland, OR 97216	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. Facility will have a quality assurance meeting with the committee (Medical Director, Infection Preventionist, DNS, Administrator and other interdisciplinary members) on 1/28/25 to review policies and procedures on TBP and COVID-19 precautions, including proper use of PPE, storage and equipment use. 8. DNS and Infection Preventionist will conduct visual audits every shift for three days, then weekly for four weeks, then monthly ongoing to ensure continued compliance with COVID and TBP requirements. 9. Audits will be reviewed by the quality assurance team monthly for six months to ensure ongoing compliance. On 1/29/25 at 9:54 AM it was determined the immediacy was removed after verification of completion of the IJ removal plan. 47000