STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385214	A. Building B. Wing	04/24/2026

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

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review it was determined the facility failed to administer the correct medications for 1 of 3 sampled residents (#45) reviewed for hospitalizations. This failure resulted in Resident 45 experiencing decreased blood pressure and hospitalization. Findings include: The facility's Administering Medications policy revised 12/2025 included the following:- Medications shall be administered in a safe and timely manner, and as prescribed.- Medications must be administered in accordance with the orders.- The individual administering medications must verify the resident's identity before giving the resident her/his medications.- The individual administering the medication must check the label three times to verify the right medication, right dosage, right time and right method of administration before giving the medication.Resident 45 was admitted to facility in 4/2026 with diagnoses including encounter for surgical aftercare following surgery on the digestive system and essential hypertension (high blood pressure).The Admissions MDS with an ARD of 4/23/26 revealed Resident 45 had a BIMS score of 14, which indicated the resident was cognitively intact. A review of Resident 45's medication administration record revealed she/he had three medications amiodarone (antiarrhythmic), losartan (treats hypertension) and metoprolol (treats hypertension) on 4/15/26 scheduled at 8:00 AM. On 4/20/26 at 11:47 AM, Resident 45 stated she/he usually only took three pills in the morning. The resident stated when the nurse handed her/him more than three pills on 4/15/26 between 8:00 AM and 8:30 AM, she/he said, This seems like a lot. Resident 45 stated the nurse informed her/him this was the amount she/he was supposed to take. Resident 45 stated she/he trusted staff to do the right thing, and consumed the medications. Resident 45 stated she/he felt very weak after receiving the medications.On 4/21/26 at 12:00 PM, Staff 14 (CNA) stated Resident 45 was usually alert, oriented and able to understand conversation and instructions. Staff 14 stated on the morning of 4/15/26, Resident 45 was very confused, not at her/his typical baseline and Staff 14 had to repeat instructions multiple times when providing cares to Resident 45. Staff 14 stated after she helped Resident 45 with showering, she was going to report Resident 45's behaviors but Staff 3 (RN/Infection Preventionist) approached her and instructed Staff 14 to lay Resident 45 down.On 4/21/26 at 12:45 PM, Staff 11 (LPN) stated he accidentally gave Resident 45 another resident's medications on the morning of 4/15/26. Staff 11 stated he was distracted with staff, residents and family and not accustomed to the area he was assigned to. Staff 11 stated he did not follow the five rights of medication (verify the right person, medication, dose, route, and time) when he handed medications to Resident 45. Staff 11 stated Resident 45 informed him she/he thought it seemed like she/he was being given a lot of medications and Staff 11 informed Resident 45 there was usually a lot of medications given in the morning. Staff 11 stated Resident 45 accepted the answer and consumed the medications. Staff 11 stated he realized his mistake and informed Staff 3 (RN/Infection Preventionist). Staff 11 stated Resident 45's vitals were checked a few times and she/he had very low blood pressure and the resident was sent out to the hospital for further evaluation.On 4/22/26 at 10:53 AM, Staff 3 (RN/Infection Preventionist) stated on the morning of 4/15/26, Staff 11 notified her of Resident 45 being given another resident's medication. Staff 3 stated she assessed Resident 45 and the resident's vitals were checked and Resident 45's blood pressure was very low. Resident 45 was sent to a hospital emergency department for further (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 0760 Level of Harm - Actual harm Residents Affected - Few	evaluation. A review of Resident 45's medication error report dated 4/15/26 revealed Resident 45 was administered 12 medications of another resident on 4/15/26 at 8:30 AM and Staff 11 realized the error at 10:09 AM.A review of Resident 45's hospital records from 4/15/26 through 4/17/26 revealed Resident 45 presented to the hospital with bradycardia (slow resting heart rate) and hypotension (low blood pressure often causing dizziness, fainting, and blurred vision) and was diagnosed with transient circulatory shock (a life-threatening failure of the cardiovascular system to deliver enough oxygen to tissues, leading to cellular hypoxia and organ dysfunction) secondary to unintentional medication overdose. Resident 45 arrived to the emergency department on 4/15/26, requiring admission to the intensive care unit and vasopressor support (a critical care intervention used to treat severe hypotension and shock).On 4/23/26 at 3:26 PM, Staff 2 (DNS) stated she was aware of the medication error that occurred on 4/15/26 and Resident 45 being sent out to the hospital for further evaluation. Staff 2 acknowledged Resident 45 was given another resident's medication and stated she expected staff to always follow the five rights of medication administration by ensuring the right resident, right medication, right dose, right route, and right time.The deficient practice was identified as Past Noncompliance based on the following:On 4/15/26, the deficient practice was identified by the facility and was corrected when the facility completed a root cause analysis of the significant medication error:1. Staff 11 was immediately educated on 4/15/26.2. The deficient practice was brought to quality assurance and a plan of correction was implemented on 4/22/26, including weekly medication pass audits.3. Provision of a Medication Administration Training in-service to all licensed staff which outlined the process to ensure the correct drug, resident, dose, route and time prior to administering medications was completed on 4/24/26.4. Ongoing QAPI review and oversight.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview it was determined the facility failed to ensure medication and treatment carts were locked and secured appropriately for 1 of 4 halls observed (200 Hall) during random observations for medication and treatment cart storage. This placed residents at risk for unsafe access to stored medications. Findings include:The facility's Security of Medication Cart policy dated 5/2010 included the following:- The nurse must secure the medication cart during the medication pass to prevent unauthorized entry.- The cart must be locked before the nurse enters the resident's room.- Medication carts must be securely locked at all times when out of the nurse's view.On 4/20/26 at 2:40 PM, Staff 17 (RN) was observed alone standing next to an unlocked medication cart in the 200 Hall. At 2:42 PM, she walked away from the cart and out of the 200 Hall. At 2:42 PM, Staff 17 was observed locking the medication cart and stated the expectation was for medication carts to be locked whenever staff was away from it. Staff 17 stated she did not have the key to the medication cart, because she was not in charge of it. Staff 17 stated she could not find the person in charge of the cart and confirmed residents' prescribed medications were in the cart.On 4/21/26 at 12:34 PM, an unlocked treatment cart was observed in the 200 Hall. Staff 18 (LPN) and another staff member were observed to be in the bistro area of the 200 Hall, not within sight of the treatment cart. At 12:35 PM, Staff 18 confirmed the treatment cart was unlocked and stated the expectation was to lock medication and treatment carts anytime he walked away from them. The treatment cart was observed to contain insulin and needles.On 4/23/26 at 3:11 PM, an unlocked medication cart was observed in the 200 Hall. At 3:12 PM, Staff 19 (RN) confirmed the cart was unlocked. Staff 19 confirmed residents' prescribed medications were in the medication cart. Staff 19 stated she was distracted and was more accustomed to working during the night shift. She stated the expectation was to lock medication and treatment carts whenever she walked away from them.On 4/23/26 at 3:39 PM, Staff 2 (DNS) stated she expected staff to lock medication and treatment carts whenever staff were away from the medication and treatment carts for safety purposes.

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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 it was determined the facility failed to ensure hand hygiene was performed during wound care for 1 of 1 sampled resident (#7) reviewed for pressure ulcer. This placed residents at risk for cross contamination. Findings include: Resident 7 was admitted to the facility in 3/2026 with a diagnosis of diabetes. The facilities Standard Precautions policy and procedure last revised 5/2010 revealed hand hygiene (washing hands with soap and water or an alcohol-based hand rub), was to be performed when hands were not visibly soiled and gloves were to be changed, as necessary, during care of a resident to prevent cross-contamination when moving from a dirty site to a clean site. On 4/21/26 at 11:14 AM Staff 15 (LPN) was observed to remove Resident 7's old pressure ulcer dressing and adjusted Resident 7's incontinent brief. Staff 15 was stopped by this surveyor prior to him cleaning Resident 7's pressure ulcer. Staff 7 stated he should have changed gloves when going from a dirty task to a clean task. Staff 7 then removed her/his gloves and prior to putting on clean gloves was stopped by this surveyor to ensure hand hygiene was performed. Staff 15 stated he should have performed hand hygiene prior to putting on clean gloves. On 4/24/26 at 9:15 AM Staff 2 (DNS) stated staff were to follow infection control standards including changing gloves as needed and preforming hand hygiene when gloves were removed.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review it was determined the facility failed to ensure residents were assessed to self-administer medications for 1 of 1 sampled residents (#9) reviewed for accident hazards. This placed resident at risk for unsafe medication administration. Findings include:The facility's Self-Administration of Drugs policy dated 5/2010 included the following:- Staff and practitioner will document their findings and the choices of residents who are potentially capable of self-administering medications.- Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents.- Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for bedside storage.Resident 9 was admitted to facility in 5/2010 with diagnosis of end stage renal disease (permanent chronic kidney failure).The Quarterly MDS with an ARD of 3/7/26 revealed Resident 9 had a BIMS score of 14, which indicated the resident was cognitively intact.A review of Resident 9's clinical record revealed no current self-administration of medication assessment was completed to determine the resident's ability to safely self-administer medications.Observations on 4/20/26 at 1:35 PM and 4/21/26 at 11:32 AM revealed Resident 9 had a large weekly pill organizer for Monday through Sunday, three times per day sitting on her/his bedside table, with 16 of 21 slots filled with pills.On 4/20/26 at 1:35 PM, Resident 9 stated the pill organizer had been on her/his bedside table for about a week. The resident stated she/he was out of the facility on a planned trip and did not take all of the pills in her/his pill organizer while she/he was out of the facility on her/his trip.A review of Resident 9's progress notes revealed she/he went out of the facility on 2/10/26 with packed medications and returned to the facility on 2/16/26.On 4/21/26 at 1:29 PM, Staff 14 (CNA), at 1:31 PM, Staff 15 (CNA) and at 2:23 PM, Staff 16 (CNA) stated they were unaware of any residents who were authorized to self-administer medications. Staff stated if medications were found on residents' bedside tables, they would inform a nurse.On 4/21/26 at 2:24 PM, Staff 12 (RN) stated staff were expected to inform a nurse if medications were observed in a resident's room. Staff 12 stated the protocol was to check in with residents after their return from a prolonged trip, which included asking about the status of medications that were packed. Was this RN aware of Resident 9's medications- if so please include here.On 4/21/26 at 2:35 PM, Staff 13 (LPN) stated he did not notice Resident 9's pill organizer the first time he entered Resident 9's room on 4/21/26 to give morning medications. Staff 13 stated he saw the pill organizer on Resident 9's bedside table when he entered Resident 9's room for the second time on 4/21/26 at 11:40 AM. He stated the pill organizer had pills from when Resident 9 went on a trip a few months ago. Staff 13 stated he removed the pill organizer from the Resident 9's room because she was not assessed for self-administration of medications.On 4/23/26 at 3:26 PM, Staff 8 (RNCM) acknowledged Resident 9 was not assessed for self-administering medications and stated she expected CNAs to inform nurses if medications were found to be in a resident's room. Staff 8 stated medications should be in a locked location and not out in the open. She stated when residents were packed medications on an outing, the protocol was for nurses to check in and inquire about the medications when residents return to the facility. Staff 8 stated a process and assessment was involved in order for residents to self-administer medications.On 4/23/26 at 3:34 PM, Staff 2 (DNS) stated she expected staff to inform a nurse immediately if medications were found by a resident's bedside. She stated a process and assessment was involved in order for residents to self-administer medications.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to ensure a resident's advance directive was filed in her/his clinical record for 1 of 1 sampled resident (#5) reviewed for advance directive. This placed residents at risk for end-of-life choices not being honored. Findings include: Resident 5 was admitted to the facility in 12/2025 with a diagnosis of cancer. Resident 5's 12/22/25 admission MDS revealed she/he was cognitively intact. Resident 5's 3/26/26 Multidisciplinary Care Conference revealed she/he and her/his family participated in the care conference. The care conference notes indicated Resident 5 had an advance directive and family was to provide a copy to the facility. Resident 5's clinical record revealed her/his advance directive was not filed. On 4/22/26 at 10:00 AM Resident 5 stated she/he had an advance directive. On 4/22/26 at 8:24 AM Staff 4 (Social Services) stated if a resident had an advance directive, she was to ensure family provided the advance directive to the facility. Staff 4 stated she did not follow-up with Resident 5's family. On 4/23/26 at 8:50 AM Staff 5 (Social Service's Director) stated if a resident had an advance staff were to follow-up with family to ensure it was in a resident's clinical record and staff were to document attempts to call family. On 4/24/26 at 8:57 AM Staff 1 (Administrator) stated if a resident had an advance directive staff should ensure it was in the clinical record as soon as able.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review it was determined the facility failed to notify a resident representative after a change of condition for 1 of 1 resident (#87) reviewed for notifications. This placed residents at risk for uninformed healthcare decisions. Findings include:Resident 87 was admitted to the facility in 11/2024 with diagnoses including surgical treatment after a hip fracture, dementia, and anxiety disorder.A Resident Designation Form from 11/8/24 stated Resident 87 elected to have Witness 2 contacted in case of emergency.A Skilled Nursing Progress Note from Staff 21 (LPN) 12/3/24 revealed Resident 87 had the onset of a new possible infection at the surgical site of her/his left hip. Staff 23 (Nurse Practitioner) and Staff 22 (RNCM) were notified of this change of condition. Staff 23 directed Staff 21 to start Resident 87 on cephalexin, (an antibiotic).A 12/3/24 Physician Order directed cephalexin to be started on 12/3/25 to address Resident 87's suspected wound infection.Review of the 12/2025 MAR revealed Resident 87 started on an antibiotic, cephalexin, on the evening of 12/3/25.A 12/5/24 progress note revealed Staff 22 (RNCM) contacted Resident 87's family regarding the suspected infection and starting an antibiotic.On 4/22/26 at 2:49 PM Witness 2 (Family Member) stated she/he requested to be notified of any change of condition experienced by Resident 87. Witness 2 stated she/he was not notified on 12/3/24 when Resident 87's had a suspected infection at the surgical site at her/his left hip. On 4/23/26 at 11:04 AM Staff 21 stated she made the Resident Care Manager aware of the suspected infection and was not aware if Resident 87's family was notified of Resident 87's change of condition.On 4/23/26 at 11:51 AM Staff 22 stated family members were contacted when a resident experiences a change of condition. Staff 22 confirmed Resident 87 was suspected to have a wound infection, and treatment was started to treat the infection on 12/3/24, but Resident 87's emergency contact was not alerted of Resident 87's change of condition until 12/5/24.On 4/23/26 at 12:29 PM Staff 2 (DNS) confirmed she would consider a potential infection a change of condition which required notification to a resident's emergency contact and Resident 87's emergency contact should have been contacted on 12/3/24.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review the facility failed to protect the resident's right to be free from misappropriation of property for 1 of 1 sampled resident (#86) reviewed for abuse. This placed residents at risk for continued depravation of goods and services. Findings include:Resident 86 admitted to the facility in 7/2025 with diagnoses including right femur fracture and major depressive disorder. The 7/31/25 admission MDS assessed Resident 86 as cognitively intact. The facility submitted a Facility Reported Incident (FRI) on 8/16/25 indicating Resident 86 received fraud alerts from her/his financial institutions and discovered two credit cards and one debit card missing. Resident 86 reported Staff 10 (Former Maintenance Assistant) had entered her/his room multiple times over the prior weeks without clear request, reportedly to check equipment. Interview with the resident's family and record review revealed fraudulent charges between 8/4/25 and 8/16/25 totaling over $1300, including a charge at a gas station in the same town where Staff 10 resided as well as miscellaneous online purchases. The employee was placed on immediate administrative leave.The facility's investigation revealed video surveillance footage confirmed Staff 10 utilized the resident's credit and debit cards at a local gas station and for miscellaneous online purchases. The facility also obtained footage of Staff 10 entering Resident 86's room on multiple occasions without a documented work order or request for maintenance services. Law enforcement was notified, and a police report was filed. The facility reimbursed Resident 86 for the fraudulent charges. A facility-wide audit was conducted to determine if other residents experienced missing property, no additional concerns were identified.Resident 86 experienced financial loss exceeding $1300 and emotional distress related to the unauthorized use of her/his personal financial accounts, which resulted in her/him electing to move rooms due to concerns for personal safety and security. On 4/21/26 at 10:24 AM Witness 1 (Family Member) confirmed the cards were kept in Resident 86's room and no permission had been given for anyone to use them. Witness 1 stated Resident 86 elected to move from her/his private room to another private room following the incident for an increased sense of security. On 4/23/26 at 9:45 AM Staff 2 (DNS) confirmed she was aware of the incident which occurred on 8/16/25 regarding Resident 86 and misappropriation of funds had occurred. Staff 2 stated it was her expectation residents were protected from misappropriation and staff did not take or utilize resident property. On 4/23/26 at 9:50 AM Staff 9 (Former Administrator) confirmed misappropriation of funds occurred on 8/16/25 regarding Resident 86 and stated Staff 10 was immediately removed from the schedule, reported to law enforcement, and subsequently terminated. Staff 9 stated she expected staff to immediately report any misappropriation concerns and always protect resident property. Staff 9 further stated the facility offered lockboxes to residents for personal belongings, and residents retain the key for added security. On 4/23/26 at 10:26 AM Staff 1 (Administrator) confirmed the 8/16/25 incident occurred and Resident 86 had funds stolen and used by Staff 10. Staff 1 stated immediate actions was taken to address the misappropriation of funds. Staff 1 stated she expected resident property was protected and staff immediately report allegations of misappropriation. On 4/24/26 at 8:57 AM Staff 10 stated he did not provide a statement regarding the allegation of resident stolen property. Staff 10 confirmed he was placed on administrative leave and was subsequently terminated. The incident met the criteria for past noncompliance as follows:The deficient practice was identified as Past Noncompliance based on the following:-On 8/16/25, the deficient practice was identified by the facility, and the facility completed a root cause analysis of the incident and determined misappropriation of funds occurred. The plan of correction included:1. Staff 10 was placed on leave pending the investigation and was subsequently terminated. 2. Staff were provided with in-services training including reeducation regarding abuse and misappropriation of funds and all required training was completed by 9/10/25.3. Audits were conducted to ensure ongoing compliance and staff adherence to appropriate practices regarding misappropriation of funds. 4. Ongoing Quality Assurance oversight.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to ensure the State Long-Term Care Ombudsman office was notified of a resident's discharge for 1 of 1 sampled resident (#85) reviewed for discharge. This placed residents at risk for lack of advocacy. Findings include: Resident 85 was admitted to the facility in 2/2026 with a diagnosis of respiratory failure. Resident 85's Clinical record revealed she/he was discharged in 2/2026. Resident 85's clinical record did not reveal the State Long-Term Care Ombudsman office was notified of her/his discharge. The facility's 1/1/26 through 3/31/26 Discharges list revealed Resident 85 was not listed as a discharged resident. On 4/23/26 at 8:58 AM Staff 6 (Business Office Manager) verified the 1/1/26 through 3/31/26 Discharge list did not include Resident 85, and this list was sent to the Ombudsman office to notify them of the facility discharged residents. On 4/24/26 at 8:57 AM Staff 1 (Administrator) stated a complete list of discharged residents were to be sent to the Ombudsman office.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review it was determined the facility failed to ensure a resident's oxygen equipment was cleaned for 1 of 1 sampled resident (#5) reviewed for respiratory care. This placed residents at risk for decreased oxygen quality. Findings include: Resident 5 was admitted to the facility in 12/2025 with a diagnosis of a stroke. Resident 5's Task form for cleaning her/his oxygen filter indicated on 4/17/26 staff cleaned her/his oxygen filter. On 4/20/26 Resident 5's oxygen filter was observed with gray/brown dust coating the filter. On 4/22/26 at 8:11 AM Staff 7 (CNA) stated the nurses were responsible for cleaning the oxygen filters. On 4/22/26 at 8:19 AM Staff 21 (LPN) stated the oxygen company managed the oxygen equipment. On /22/26 at 11:44 AM Staff 8 (RNCM) verified Resident 5's oxygen filter was coated with dust and the amount of dust present likely did not build up after 4/17/26. On 4/24/26 at 9:15 AM Staff 2 (DNS) stated staff were to clean the oxygen filters weekly.