

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Marquis Vermont Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 6010 SW Shattuck Road Portland, OR 97221	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>50928</p> <p>Based on observation, interview and record review the facility failed to revise the plan of care to reflect residents' needs for 1 of 1 sampled resident (#29) reviewed for hospice. This placed residents at risk for unmet care needs. Findings include:</p> <p>Resident 29 was admitted to the facility in 9/2023 with diagnoses of dementia and hip fracture.</p> <p>Resident 29's 10/15/24 Quarterly MDS indicated he/she required partial to moderate assistance with eating.</p> <p>Resident 29's 10/15/24 Care Plan indicated he/she required one-on-one supervision, set up, and eating assistance for all meals.</p> <p>Multiple random observations from 12/17/24 through 12/18/24 revealed:</p> <p>-12/17/24 at 10:21 AM Resident 29 was observed sitting upright in bed with a cup of ice cream placed directly in front of him/her on an overbed table without supervision.</p> <p>-12/17/24 at 12:28 PM Resident 29 was observed sitting upright in bed with a lunch tray placed directly in front of him/her on an overbed table without supervision during mealtimes.</p> <p>-12/18/24 at 8:27 AM Resident 29 was observed sitting upright in bed with a breakfast tray placed directly in front of him/her on an overbed table without supervision during mealtimes.</p> <p>On 12/18/24 at 8:41 AM Staff 12 (CNA) stated during mealtimes she provided frequent checks on Resident 29. Staff 12 stated she sat with him/her to assist with eating after meal tray pass had been completed and if the resident had not finished his/her meal.</p> <p>On 12/18/24 at 12:05 PM Staff 2 (DNS) confirmed the expectation was to provide one-on-one supervision during all meals and for staff to be present in the resident's room to ensure assistance had been provided throughout the entire meal period.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/19/24 at 8:55 AM Staff 11 (RCM) stated Resident 29 was care planned for one-on-one supervision at all mealtimes due to the resident's cognitive impairment and his/her pattern of sleeping through meals. Staff 11 stated it was appropriate to update Resident 29's care plan to reflect less supervision during meal times.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43690</p> <p>Based on interview and record review it was determined the facility failed to obtain a physician order for a respiratory device and ensure resident respiratory equipment was maintained for 1 of 1 sampled resident (#14) reviewed for respiratory care. This placed residents at risk for increased respiratory concerns. Findings include:</p> <p>Resident 14 was admitted to the facility in 12/2024 with diagnoses including Alzheimer's disease and obstructive sleep apnea.</p> <p>The Annual MDS dated [DATE] indicated Resident 14 did not utilize a CPAP (continuous positive airway pressure) machine .</p> <p>A review of physician orders from 12/2024 revealed Resident 14 had no orders for use of a CPAP machine.</p> <p>A review of Resident 14's Care Plan and TAR from 12/2024 revealed no instructions for maintenance of the CPAP machine.</p> <p>On 12/17/24 at 10:41 AM Staff 5 (LPN) indicated Resident 14 used her/his CPAP machine at night. Staff 5 stated Resident 14 used her/his CPAP machine since her/his admitted and Staff 5 had cleaned it with distilled water at least two times but had no way to document the maintenance.</p> <p>On 12/17/24 11:10 AM Staff 3 (RNCM) confirmed Resident 14 had a diagnosis of sleep apnea and did not have a physician's order for use of a CPAP machine nor was the CPAP machine care planned to be maintained weekly.</p> <p>On 12/17/24 at 12:33 PM Staff 4 (NP) stated there should have been an order in place for Resident 14 prior to the CPAP machine being used.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46053</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure foods were labeled and stored in a way to minimize food spoilage in 1 of 1 kitchen reviewed for sanitation. This placed residents at risk for potential infections related to foodborne pathogens. Findings include:</p> <p>The facility's undated Storage of Frozen and Refrigerated Foods policy specified the following:</p> <ul style="list-style-type: none"> <li>-Food needs to be labeled with name of the product if removed from the original packaging.</li> <li>-No food should be stored past the expiration date.</li> </ul> <p>On 12/16/24 at 9:20 AM during the initial tour of the facility's kitchen, the following was observed in the walk-in refrigerator:</p> <p>A rolling rack containing trays of multiple undated salad items under large sheets of plastic cling film:</p> <ul style="list-style-type: none"> <li>-Partially-filled multi-use plastic bins of red beans, cottage cheese, diced hard-boiled eggs, carrots, shredded cheese;</li> <li>-Multi-use plastic bins of full of chopped beets, chopped bacon, garbanzo beans;</li> <li>-Two nearly empty multi-use plastic bins of salad dressings; and</li> <li>-A large multi-use plastic bin of chopped greens.</li> </ul> <p>On adjacent shelving, the following was observed:</p> <ul style="list-style-type: none"> <li>-A tray of 25 individually covered juice glasses on top of another tray full of similar juice glasses; and</li> <li>-Four trays with multiple covered disposable plastic condiment ramekins. There were no labels or dates on the items or on the trays.</li> </ul> <p>On 12/16/24 at 9:39 AM Staff 7 (Dietary Manager) acknowledged the items which were not labeled or dated and stated they should be labeled and dated to know when they were prepared and when they should be discarded.</p> <p>On 12/19/24 at 11:57 AM Staff 1 (Administrator) stated she was aware of the labeling issue and stated she expected items in the kitchen to be labeled and dated.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>46053</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure the garbage area dumpsters were covered and free from debris for 1 of 1 facility dumpster reviewed for sanitation. This placed residents at risk for exposure to used medical supplies. Findings include:</p> <p>The facility's undated Food/Waste Disposal policy specified the following:</p> <ul style="list-style-type: none"> <li>-Dumpster lids are to be closed at all times.</li> <li>-Dumpster and dumpsite area is to be kept clean and free of debris.</li> </ul> <p>On 12/16/24 at 9:39 AM the garbage dumpster located adjacent to the kitchen's side doorway (below the facility's E hall) was observed to be open with used examination gloves, sweetener packets, paper towels, and plastic spoons scattered on the ground at the base. A CNA stood on the railed walkway above the dumpster and threw a clear plastic bag over the railing into the dumpster. Staff 7 (Dietary Manager) stated the lid was always open to allow CNAs to throw waste into the dumpster from the end of the E hallway above. She stated this was the reason for the garbage on the ground and she cleaned it every morning. Staff 7 stated she would clean the area again and keep the dumpster closed to minimize the risk of attracting vermin to the kitchen door.</p> <p>On 12/17/24 at 8:41 AM the same dumpster adjacent to the kitchen's side doorway was observed open with large plastic garbage bags visible inside the dumpster.</p> <p>On 12/17/24 at 9:45 AM the garbage dumpster was observed from the railed walkway above to be open with plastic garbage bags inside.</p> <p>On 12/17/24 at 2:29 PM Staff 9 (CNA) was observed with a bag of garbage in the E hallway. She opened the door at the end of the hallway, walked onto the railed walkway and threw the bag of garbage over the railing to the dumpster below. Staff 9 stated the garbage dumpster below was never closed as long as she worked in the facility. She stated she tied the bags because they contained garbage from residents' rooms including incontinence briefs.</p> <p>On 12/17/24 02:37 PM Staff 10 (CNA) was observed to throw a bag of garbage over the railing into the open dumpster below. Staff 10 stated she and other CNAs always threw the garbage bags over the railing and the garbage dumpster was never closed.</p> <p>On 12/18/24 11:26 AM Staff 7 stated she discussed the garbage dumpster situation with facility staff because they wanted to develop a way for the dumpster to be used by CNAs and kitchen staff while keeping it closed when it was not in use.</p> <p>On 12/19/24 at 11:57 AM Staff 1 (Administrator) acknowledged the issue with the garbage dumpster being left open and stated she expected the garbage dumpster to be kept closed and the area around it to be clean to minimize the risk of vermin being attracted to the area.</p>		