STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385218	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Vermont Hills	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review it was determined the facility failed to ensure residents were free from unwanted sexual contact by Witness 2 (Non-Family Visitor) for 1 of 1 sampled Resident (#12) reviewed for abuse. This placed residents at risk for unwanted sexual contact and mental anguish. Findings include: Sexual abuse is defined as nonconsensual sexual contact of any type with a resident as defined at 42 CFR S483.5. Sexual contact is considered nonconsensual if the resident either:-Appears to want the contact to occur, but lacks the cognitive ability to consent; or-Does not want the contact to occur.Resident 12 was admitted to the facility in 1/2025 with diagnoses including vascular dementia (a type of dementia caused by reduced blood flow to the brain, leading to cognitive decline).Resident 12's 3/29/26 Quarterly MDS indicated the resident had moderate cognitive impairment.Random observations from 5/18/26 through 5/22/26 between the hours of 8:00 AM through 4:00 PM revealed Resident 12 and Resident 52 shared a room. Residents 12 and Resident 52 were observed in the rotunda multiple times interacting with staff and engaging in activities. Resident 12 was observed ambulating in the hallways and common areas with her/his walker and Resident 52 was observed visiting with a family member in the dining room. No visits from Witness 2 were observed during this time.On 5/18/26 at 2:14 PM Resident 12 stated she/he did not remember being kissed by a male visitor at the facility but indicated she/he would not have welcomed the contact. On 5/21/26 at 8:18 AM Resident 52 stated she/he would not describe Witness 2 as a friend and did not know why he visited. Resident 52 indicated she/he did not enjoy Witness 2's visits and stated, he acts funny. Resident 52 was unable to further explain the statement but responded, yes, when asked if she/he would prefer Witness 2 not return to the facility.On 5/20/26 at 2:11 PM Witness 2 (Non-Family Visitor) stated he visited Resident 12's roommate (Resident 52) regularly over the past several years. Witness 2 stated he developed an affection for Resident 12 over time. On the day of the incident Witness 2 stated he was alone with Resident 12 in her/his room and asked the resident if he could kiss her/him to which she/he responded, I suppose so. Witness 2 admitted to kissing Resident 12. Witness 2 acknowledged Resident 12 had dementia and cognitive impairment but stated he did not believe the kiss was inappropriate because he asked permission. On 5/20/26 at 3:50 PM Witness 4 (Family Member) stated they visited Resident 12 soon after the incident. When asked about the incident, Resident 12 indicated the kiss caught her/him by surprise and stated, I don't know why he did that, and expressed she/he did not want it to happen. Witness 4 stated Resident 12 was conservative by nature, and he did not believe the resident invited, welcomed or meaningfully consented to sexual contact with Witness 2.On 5/19/26 at 12:06 PM Staff 24 (Receptionist) stated Witness 2 made staff feel uncomfortable and put off a bad vibe. Staff 24 stated concerns regarding Witness 2 had been informally mentioned to nursing leadership prior to the incident with Resident 12 but were not formally reported to leadership.On 5/19/26 at 2:12 PM Staff 25 (CNA) stated while in the dining room Witness 2 stared at her for a prolonged period and started singing her name while continuing to stare. Staff 25 stated Witness 2 asked for her phone number, and she declined to give it. Staff 25 indicated Witness 2's behavior made her feel unsafe and uncomfortable. Staff 25 requested Staff 1 (Administrator) to relieve her from her duties in the dining room so she could leave the (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediate area. When Witness 2 was no longer visible in common areas, Staff 25 checked Resident 12's room out of concern. Staff 25 saw the privacy curtain was drawn around Resident 12's bed. Staff 25 heard Witness 2's voice and saw his shoes behind the curtain. Staff 25 alerted Staff 2 (DNS) of what she observed, and Staff 2 told Witness 2 to leave the room. Staff 25 stated Resident 12 reported Witness 2 kissed her/him on the mouth and appeared visibly uncomfortable and confused afterward. Staff 25 stated Staff 2 confronted Witness 2 and told him to leave the facility. Staff 25 stated Witness 2 had visited Resident 52 before and could tell the resident was not comfortable with him. Staff 25 stated they were aware other CNAs had a bad feeling about Witness 2 and would keep an eye on him during visits prior to the incident but did not believe it was reported to leadership. On 5/19/26 at 3:42 PM Staff 26 (CNA) stated Witness 2 focused heavily on female residents and female staff, made off-putting comments, and caused discomfort among staff. On 5/21/26 at 3:49 PM Staff 9 (Social Services Director) stated Witness 2 came to the facility to primarily visit Resident 52. Staff 9 stated there was a general feeling among staff that Witness 2 was creepy and staff knew to keep an eye on him. Staff 9 indicated Witness 2 was overly focused on female residents and female staff and was aware Witness 2 had asked some younger female staff for their phone numbers prior to the incident with Resident 12. Staff 9 stated prior to the incident with Resident 12 he was aware Witness 2 asked another female/male resident in skilled care at the facility for her/his phone number. Staff 9 did not know if Witness 2 had been talked to directly about his behavior. Staff 9 stated Resident 52 would express she/he was okay with Witness 2's visits when asked and did not indicate she/he wanted him to leave, additionally there were no objections by the family with Witness 2 visiting. Staff 9 further stated staff were expected to report concerns regarding visitors, including uncomfortable or uneasy feelings or the need to closely monitor a visitor, to the nearest leader. Staff 9 acknowledged staff concerns with Witness 2's behavior were not reported despite ongoing observations of inappropriate boundary-related behaviors. On 5/22/26 at 11:19 AM Staff 2 stated Witness 2 demonstrated repeated boundary violations during visits by asking medical questions of other residents, speaking loudly in the common areas, and offering food and drinks to residents, including those that required eating assistance. Staff 2 stated Witness 2 had to be reminded to be careful of the appropriateness of his behavior. Staff 2 stated she was unaware prior to the incident with Resident 12 that staff were uncomfortable with Witness 2, that he was overly focused on female residents and female staff, or that he had asked another resident for a phone number. Staff 2 stated she would expect staff to report any concerns related to inappropriate behaviors by visitors.On 5/22/26 at 8:40 AM Staff 1 stated the facility notified the police after the incident with Resident 12 and the responding officer indicated there was something found in Witness 2's background but did not elaborate or provide a report. Staff 1 stated staff were expected to report any visitor behavior they found concerning, inappropriate, or uncomfortable to leadership. Staff 1 acknowledged leadership was not fully aware of the widespread staff discomfort with Witness 2 or staff monitoring of his behavior until after the incident with Resident 12 and stated the concerns should have been reported earlier.The deficient practice was identified as Past Noncompliance based on the following:On 3/26/26 the deficient practice was identified by the facility and corrected with the following actions:-The visitor was immediately removed on 3/23/26 from the facility and informed he was no longer permitted to visit the facility.-Family members were promptly notified of the incident.-A report was submitted to the Portland Police Department.-Staff were instructed to monitor for any potential return of the visitor and to observe the resident for any changes in condition or behavior.-Interviews with residents were conducted and revealed no prior encounters from Witness 2.-Staff received education regarding reportable events and mandatory reporting requirements to the state and the facility's investigation process.-Ongoing QAPI regarding abuse.