

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2024
NAME OF PROVIDER OR SUPPLIER Marquis Oregon City Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1680 Molalla Avenue Oregon City, OR 97045	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42222</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from abuse for 1 of 4 sampled residents (#7) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>Resident 7 admitted to the facility in 3/2020, with diagnoses including unspecified dementia and acute kidney failure.</p> <p>Resident 7's Quarterly MDS dated [DATE] revealed a BIMS score of 4, which indicated severe cognitive impairment.</p> <p>Resident 8 admitted to the facility in 8/2022 with diagnoses including Alzheimer's Disease and diabetes.</p> <p>Resident 8's Progress Note revealed on 9/14/22, she/he was observed trying to touch other residents in the groin area. When confronted by staff, Resident 8 would stop what she/he was doing and move onto the next closest female/male and start to grab their hands and then slowly rub their leg and try to creep her/his hand slowly to their groin area. Patient was redirected several times.</p> <p>Resident 8's Quarterly MDS dated [DATE] revealed a BIMS score of 9, which indicated moderate cognitive impairment.</p> <p>Resident 8's most recent care plan, revised on 7/10/23 revealed the resident had both verbal and physical inappropriate sexual behaviors, which included a history of inappropriately touching residents of the opposite gender since 2022. Resident 8's care plan interventions included one to one supervision as needed, supervision during group activities and meal times, staff to seat resident next to the same gender in group activities and line of sight supervision if one to one supervision could not be provided.</p> <p>On 3/13/23 the State Survey Agency (SSA) received a Facility Reported Incident (FRI), which revealed on 3/13/23 at 3:25 PM, Resident 8 was observed by staff with her/his hand down the front of Resident 7's pants. The residents were in the dining room watching a movie and Staff 9 (Former Activities Director) left the dining room briefly. When Staff 9 returned to the dining room, she observed the incident. The residents were separated and assessed by Staff 9. The report indicated Resident 7 did not experience psychosocial distress as a result of the incident.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Progress Note dated 3/13/23 at 11:40 PM, revealed after the incident Resident 8 was placed on 15 minute checks.</p> <p>Resident 8 was not interviewed due to discharging from the facility.</p> <p>On 7/24/24 at 9:59 AM, Resident 7 was observed to be lying in bed. She/he had no recall of the incident.</p> <p>On 7/24/24 at 10:15 AM, Staff 10 (CNA) recalled both residents and noted Resident 8 was just a little too friendly with residents of the opposite gender and was to be closely supervised while out of her/his room.</p> <p>On 7/26/24 at 1:55 PM, Staff 7 (Life Enrichment Coordinator) recalled the incident and stated staff were instructed to keep an eye on Resident 8, not leave her/him with other female/male residents due to her/his behaviors which included her/him rubbing or touching other resident's bodies without their consent.</p> <p>On 7/29/23 at 11:38 AM, Staff 5 (RCM) stated Resident 8 was placed on one to one supervision in 7/2023 due to another incident involving a different resident. She stated the 3/2023 incident with Resident 7 resulted in Resident 8 being placed on 15 minute checks and not seated by residents of the opposite gender.</p> <p>On 7/29/24 at 1:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) were notified of the investigative findings.</p>		