STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385221	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Oregon City Post Acute Rehab	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50897 Based on observation and interview the facility failed to ensure a clean, home-like environment for 1 of 1 memory care units and 1 of 1 dining halls observed. This placed residents at risk for lessened quality of life. Findings include: On 10/22/24 at 11:58 AM an observation during lunch service in the main dining room revealed the light fixtures had built up debris and dead insects inside eight of eight ceiling lights. On 10/24/24 at 10:45 AM an observation near the exit of the Memory Care Unit revealed debris and dead insects accumulated on two vent covers, and in one ceiling light fixture. On 10/24/24 at 11:19 AM and 11:57 AM Staff 14 (Maintenance Director) stated he usually cleaned vents annually and cleaned the light fixtures when he noticed they were dirty or someone told him they needed cleaning. Staff 14 stated the design of the lights was perfect for catching dust and insects like a bowl. Staff 14 acknowledged the vents and light fixtures were not clean.

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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43691 Based on interview and record review it was determined the facility failed to protect the resident's right to be free from physical and mental abuse by a resident for 1 of 1 resident (# 32) reviewed for abuse. This placed residents at risk for psychosocial harm. Findings include: Resident 38 was admitted to the facility in 6/2023 with diagnoses including dementia with behavioral disturbance. Resident 32 was admitted to the facility in 9/2024 with diagnoses including dementia with behavioral disturbance. A 9/20/24 Behavior/Psychotropic Meeting report included Resident 38 exhibited behavior problems including grabbing others on 9/11/24 and screaming at others on 9/23/24. A 9/25/24 Resident to Resident Event Assessment reported Staff 16 (CNA) heard two residents yelling in a room. Staff 16 entered the room and found Resident 38 straddling Resident 32 with her/his hands around Resident 32's neck. Staff 16 was required to intervene to remove Resident 38 off of Resident 32. The report indicated Resident 38 reported, [Resident 32] was yelling and I told [her/him] I was going to kick [her/his] ass. The report indicated at that point Resident 38 got out of bed and put her/his hands around Resident 32's neck. On 10/23/24 at 10:05 AM Staff 16 (CNA) recalled the incident and stated he overheard yelling from Resident 32 and Resident 38's shared room. Staff 16 stated he was required to pull Resident 38 off Resident 32 and remove Resident 32 from the shared room. Staff 16 stated Resident 32 was distressed initially after the incident, but was able to calm down after an hour or two. On 10/23/24 at 10:14 AM Staff 17 (LPN) recalled Resident 32 stating she/he did not want to return to the room shared with Resident 38 after the incident. On 10/23/24 at 12:32 PM Staff 2 (DNS) confirmed the incident occurred and stated Resident 38's behavior towards Resident 32 was unacceptable. The identified deficient practice was determined to be past noncompliance as the facility put interventions in place to prevent additional incidents and in-serviced staff. The deficient practice was determined to be corrected on 10/10/24.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 36494 Based on interview and record review it was determined the facility failed to ensure the MDS was coded accurately related to the use of hearing devices for 1 of 2 sampled residents (#9) reviewed for hearing. This placed residents at risk for unassessed needs. Findings include: Resident 9 was admitted to the facility in 2019 with diagnoses including Parkinson's and anxiety. The 8/14/24 Annual MDS indicated the resident did not use hearing aids. The 8/14/24 Communication CAA revealed Resident 9 had a hard time hearing and often needed staff to raise their voice level when speaking to the resident. Staff were to speak in an elevated tone and face the resident when conversing. The CAA indicated Resident 9 did not use hearing aid devices but may eventually need hearing aids if her/his hearing worsened. On 10/23/24 at 3:05 PM and 10/24/24 at 11:52 AM Staff 3 (Social Services) stated the resident utilized hearing aids. Staff 3 stated she completed the 8/14/24 Annual MDS and Communication CAA, and acknowledged both were inaccurate.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 36494 Based on observation, interview and record review it was determined the facility failed to ensure staff assisted a resident with wearing hearing aids for 1 of 2 sampled residents (#35) reviewed for hearing. This placed residents at risk for a decline in communication. Findings include: Resident 35 was admitted to the facility in 7/2024 with diagnoses including dementia and anxiety. Review of Resident 35's Care Plan, revised on 8/16/24, revealed the resident had adequate hearing with hearing aids. Staff were instructed to place Resident 35's hearing aids in her/his ears in the morning, remove them at night, and place them on a charger on the night stand in a green container. Resident 35 might decline to wear her/his hearing aids due to them not being comfortable. A 9/11/24 Significant Change MDS revealed Resident 35 used hearing aids and her/his hearing was adequate. Resident 10 had a BIMS score of 10, indicating moderate cognitive impairment. A review of Resident 35's clinical record revealed no indication Resident 35 refused to have her/his hearing aids placed in her/his ears. On 10/21/24 at 11:24 AM Witness 2 (Family Member) stated when she visited Resident 35 during the day, the resident never had her/his hearing aids in. Witness 2 stated she placed them in the resident's ears and brought the concern up with staff but was not sure if anything was done to address the concern. On 10/22/24 at 11:00 AM Resident 35 stated she/he required assistance with putting her/his hearing aids in and staff did not always offer to assist with the hearing aids. Resident 35 stated she/he was hard of hearing without them. Random observations from 10/22/24 through 10/24/24 revealed Resident 35 had two hearing aids on her/his night stand in a green container being charged and not in Resident 35's ears. On 10/23/24 at 10:07 AM Resident 35 was heard asking staff to put in her/his hearing aids, however, no staff responded to her/his request, and multiple staff were in and out of the resident's room. On 10/23/24 at 10:44 AM Staff 5 (CNA), and at 1:01 PM Staff 6 (CNA), both stated Resident 35 was very hard of hearing and used hearing aids. Staff 5 acknowledged Resident 35 did not have her/his hearing aids in. Staff 5 and Staff 6 stated at times Resident 35 refused to wear the hearing aids, and they were supposed to document the refusals and report to the charge nurse. On 10/23/24 at 3:39 PM Staff 7 (CNA) stated Resident 35 was hard of hearing and required assistance with her/his hearing aids. Staff 7 stated the resident did not always have them in her/his ears when he came on shift. Staff 7 stated the hearing aids definitely helped with Resident 35's hearing. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 1:56 PM, Staff 4 (RNCM) stated Resident 35 required assistance with hearing aids being placed in her/his ears. Staff 4 stated Witness 2 reported concerns regarding the resident's hearing aids not being placed in her/his ears. Staff 4 stated she expected staff to offer to place Resident 35's hearing aids in the resident's ears. If Resident 35 refused, staff were to document in the clinical record and report the refusal to the charge nurse. Staff 4 acknowledged Resident 35's hearing aids were not being offered or placed in her/his ears.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 47001 Based on observation, interview, and record review it was determined the facility had a medication error rate of greater than 5%. The facility's error rate was 18% with six errors in 33 opportunities. This placed residents at risk for inaccurate medication dosage and adverse consequences related to medications. Findings include: 1. Resident 14 admitted to the facility in 11/2019 with diagnoses including dementia. A review of Resident 14's physician orders revealed a 9/25/24 order for acidophilus pectin (probiotic) daily. On 10/23/24 at 9:24 AM Staff 13 (CMA) was observed administering medication to Resident 14. Staff 13 did not administer acidophilus pectin. A review of Resident 14's MAR revealed Staff 13 indicated she administered acidophilus pectin with the morning medications on 10/23/24. On 10/23/24 at 9:57 AM Staff 13 stated she did not administer acidophilus pectin. Staff 13 stated there was no acidophilus pectin in the medication cart and she was going to get a bottle from the medication storage room and administer it. On 10/23/24 at 10:04 AM Staff 4 (RNCM) stated medications were to be signed out when they were given and Staff 13 should have obtained the medication prior to signing it out. 2. Resident 19 admitted to the facility in 9/2024 with diagnoses including right knee pain. A review of Resident 19's physician orders revealed a 9/25/24 order for Lidocaine 5% patch: apply two patches, one to the posterior right knee and one to the anterior right knee. On 10/23/24 at 9:06 AM Staff 13 (CMA) was observed applying one lidocaine patch to Resident 19's right knee. On 10/23/24 at 9:58 AM Staff 13 stated she was unaware the orders stated to apply two lidocaine patches. On 10/23/24 at 10:10 AM Staff 12 (RNCM) stated she expected staff to read and follow the physician orders. Staff 12 stated two lidocaine patches should have been applied per physician orders. 3. Resident 45 admitted to the facility in 7/2024 with diagnoses including depression. a. A review of Resident 45's physician orders revealed an 10/22/24 order for acidophilus pectin (probiotic) daily. On 10/23/24 at 8:46 AM Staff 13 (CMA) was observed administering Resident 45's medications. Staff 13 did not administer acidophilus pectin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 10:02 Staff 13 acknowledged she did not administer acidophilus pectin. Staff 13 stated there was no acidophilus/pectin in the medication cart and she was going to get a bottle from the medication storage room and administer the medication. On 10/23/24 at 10:12 AM Staff 12 (RNCM) stated medications were to be signed out when they were given and Staff 13 should have obtained the medication prior to signing it out. b. A review of Resident 45's physician orders revealed a 10/22/24 order for apripazole (a medication to treat depression) 7.5 mg daily. On 10/23/24 at 8:46 AM Staff 13 (CMA) was observed administering Resident 45's medications. Staff 13 administered apripazole 5 mg. On 10/23/24 at 10:02 Staff 13 acknowledged she did not administer the correct dose of apripazole. On 10/23/24 at 10:12 AM Staff 12 (RNCM) stated staff were expected to read and follow physician orders. c. A review of Resident 45's physician orders revealed a 10/22/24 order for budesonide formoterol fumarate inhaler: rinse with water and spit after each dose. On 10/23/24 at 8:46 AM Staff 13 (CMA) was observed administering Resident 45's budesonide formoterol fumarate inhaler without having Resident 45 rinse and spit after each dose. On 10/23/24 at 10:02 AM Staff 13 acknowledged she did not have Resident 45 rinse and spit after administering her/his inhaler. On 10/23/24 at 10:12 AM Staff 12 (RNCM) stated staff were expected to read and follow physician orders. 4. Resident 255 admitted to the facility in 10/2024 with diagnoses including chronic obstructive pulmonary disease. A review of Resident 255's physician orders revealed a 10/21/24 order for aclidinium bromide inhaler: rinse mouth after use. On 10/23/24 at 8:58 AM Staff 13 (CMA) was observed administering Resident 255's aclidinium bromide inhaler. Staff 13 did not have Resident 255 rinse her/his mouth after using the inhaler. On 10/23/24 at 10:00 AM Staff 13 stated she was unaware of the instructions to rinse the mouth after use of Resident 255's inhaler. On 10/23/24 at 10:10 AM Staff 12 (RNCM) stated staff were expected to read and follow physician's orders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47001 Based on observation and interview it was determined the facility failed to ensure medication storage was free of expired biologicals for 1 of 1 medication room reviewed for medication storage. This placed residents at risk for diminished treatment efficacy. Findings include: On [DATE] at 1:52 PM the medication storage refrigerator was observed to have three open vials of aplisol (tuberculosis test solution) with open dates in ,d+[DATE]. Each bottle indicated to discard 30 days after opening. On [DATE] at 1:56 PM Staff 2 (DNS) stated aplisol was to be discarded per the manufacturer's recommendation, 30 days after opening the vial. Staff 2 acknowledged all three vials of aplisol were open for greater than 30 days and needed to be discarded.