

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Marquis Hope Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1577 S Ivy Canby, OR 97013	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179</p> <p>Based on observation, interview and record review the facility failed to implement enhanced barrier precautions for residents with diabetic wounds for 1 of 3 sampled residents (#2) reviewed for skin conditions. This placed residents at risk for facility acquired infections. Findings include:</p> <p>Resident 2 admitted to the facility on [DATE] with diagnoses including diabetic ulcers.</p> <p>Resident 2's 4/9/25 wound care orders instructed staff to apply idosorb 0.9% to the resident's diabetic foot ulcers, cover with gauze, and secure with a foam dressing daily.</p> <p>There was no evidence in Resident 2's medical record that she/he was on enhanced barrier precautions for her/his diabetic ulcers.</p> <p>On 4/10/25 at 11:43 AM, observation of Resident 2's wound revealed Staff 3 (LPN) did not wear a PPE gown and utilize enhanced barrier precautions when she completed wound care to the resident's three diabetic foot ulcers.</p> <p>On 4/10/25 at 12:57 PM, Staff 3 verified she did not wear a PPE gown when she completed Resident 2's wound care.</p> <p>On 4/10/25 at 12:59 and 1:10 PM, Staff 2 (DNS/Infection Preventionist) acknowledged Staff 3 did not follow enhanced barrier precautions when she completed Resident 2's wound care.</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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