STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385260	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Hope Village	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)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 51845 Based on observation, interview and record review it was determined the facility failed to identify, in a timely manner, a resident who experienced a significant change in status for 1 of 2 sampled residents (#18) reviewed for accidents. This placed residents at risk for injuries and unidentified care needs. Findings include: Resident 18 was admitted to the facility in 3/2025 with diagnoses including falls. Resident 18's 3/26/25 Admission MDS indicated the resident was cognitively intact and had no behavioral symptoms, including wandering. The resident had no functional limitations and was able to use her/his upper extremity freely. A 4/30/25 Unwitnessed Fall Investigation revealed Resident 18 fractured her/his left arm when she attempted to self-transfer to the bed. A 5/1/25 progress note revealed Resident 18 was to be monitored and placed on alert charting for 14 days to determine if the resident experienced a significant change in condition. A review of Resident 18's medical record revealed no indication the resident refused care or was placed on alert charting. On 5/22/25 at 9:35 AM, Staff 11 (CNA) stated Resident 18 was not resistant to care when she/he was admitted to the facility but had since become resistant to care. Staff 11 stated Resident 18 exhibited verbal aggression toward staff. Staff 11 stated Resident 18 was able to perform peri-care and complete upper body dressing independently. On 5/22/25 at 10:53 AM Resident 18 was observed in another resident's room and looked through papers on the bedside table. Resident 18 looked through another resident's personal papers without asking for permission and the other resident was unaware of the incident. On 5/22/25 at 11:23 AM, Staff 13 (CNA) stated Resident 18's functional status declined after sustaining a fracture. Staff 13 stated the resident did not have behaviors and was able to complete upper body tasks independently when she/he admitted to the facility. Staff 13 stated Resident 18 experienced a change in her/his baseline, refused care and wandered the halls. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/25 at 12:38 PM, Staff 4 (Social Service Director) stated Resident 18 was cognitively intact and able to make decisions about her/his care upon admission but had since become cognitively impaired. Staff 4 stated Resident 18 was moderately impaired for decision-making. Additionally, Staff 4 stated Resident 18 had not exhibited behaviors at the time of admission but later voiced suicidal ideations and threatened her/his roommate. On 5/22/25 at 2:55 PM, Staff 14 (LPN Resident Care Manager) stated she/he was unsure of the criteria of when to complete a Significant Change of Condition Assessment. Staff 14 stated she placed Resident 18 on alert charting for two weeks. She acknowledged no progress note was made to determine if the resident experienced a significant change and needed to converse with Staff 2 (DNS). On 5/22/25 at 3:54 PM, Staff 2 stated no progress note was made regarding a significant change of condition. Staff 2 acknowledged Resident 18's cognition and functional abilities changed. Staff 2 stated she was unsure if Staff 14 spoke to the staff about recent ADL decline. Staff 2 acknowledged a significant change of condition assessment should have been completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51845 Based on observation, interview and record review it was determined the facility failed to ensure care plan interventions were in to prevent falls for 1 of 2 sampled residents (#18) reviewed for accidents. This placed residents at risk for injuries. Findings include: Resident 18 was admitted to the facility in 3/2025 with diagnoses including fracture of the humerus (a bone which connects the shoulder to the elbow). The Admission MDS dated [DATE] indicated Resident 18 was cognitively intact and she/he had a history of falls with no fractures in the last six months. A review of Resident 18's medical record revealed the resident fell on ce on 3/28/25, twice on 4/14/25, once on 4/30/25 and once on 5/11/25. Resident 18's 5/11/25 Care Plan revealed the following: -The resident was to be seated in a high visibility area. -The resident was to have a visual cue in her/his room to remind her/him to use the call light. -The resident was on frequent checks. -The resident was not allowed to be left alone in her/his room unsupervised. A observation on 5/20/25 at 11:38 AM revealed Resident 18 had no visual cues or reminders in her/his room to utilize the call light. A observation on 5/20/25 from 4:40 PM to 4:50 PM, revealed Resident 18 was in her/his wheelchair by the front door of her/his room and no staff were present. On 5/22/25 at 9:35 AM, Staff 11 (CNA) stated he was unaware if Resident 18 was on frequent checks and stated all residents are on fall precautions. On 5/22/25 at 10:25 AM, Staff 12 (CNA) stated she was unaware if Resident 18 had any recent falls. Staff 12 stated she was unsure how often she was supposed to check on Resident 18. On 5/22/25 at 10:53 AM Resident 18 was observed in another resident's room and looked through papers on the bedside table. Resident 18 looked through another resident's personal papers without asking for permission. On 5/22/25 at 11:23 AM, Staff 13 (CNA) stated Resident 18 wandered the hallways often. Staff 13 stated she was unsure how often the resident needed to be checked on but thought Resident 18 should be supervised because she/he made threats to leave the facility. Staff 13 stated she had not observe any visual cues in the resident's room to remind her/him to use the call light. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/25 at 2:55 PM, Staff 14 (LPN/Resident Care Manager) stated Resident 18 should have a visual cue reminder in the room to remind her/him to use the call light and was unaware one was not in the resident's room. Staff 14 stated she expected staff to frequently check on Resident 18 which she defined as every 15 minutes. Staff 14 further stated Resident 18 was not to be left alone in the room when she/he was up and in her/his wheelchair. On 5/22/25 at 3:54 PM, Staff 2 (DNS) acknowledged the Resident 18 had no visual cues posted in her/his room to remind the resident to utilize the call light. Staff 2 stated staff were expected to implement and follow the care plan and acknowledged the care plan was not followed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 50928 Based on interview and record review it was determined the facility failed to ensure CNA staff annual performance reviews were completed for 3 of 3 sampled CNA staff (#s 7, 8 and 9) reviewed for sufficient and competent nurse staffing. This placed residents at risk for a lack of competent staff. Findings include: A review of personnel records on 5/22/25 indicated the following employees had not received their annual performance evaluations: -Staff 7 (CNA), hired date was 2/2019 and a performance review was not completed. -Staff 8 (CNA), hired date was 1/2019 and a performance review was not completed. -Staff 9 (CNA), hired date was 4/2020 and a performance review was started in 4/2025 and not completed. On 5/23/25 at 9:45 AM PM Staff 2 (DNS) confirmed annual performance reviews were not completed for Staff 7, Staff 8 and Staff 9.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51311 Based on observation, interview and record review it was determined the facility failed to ensure dental services were provided for 1 of 2 sampled residents (#19) reviewed for activities of daily living. This placed residents at risk for lack of dental care needs. Findings include: Resident 19 was admitted to the facility in 4/2024 with diagnoses including major depressive disorder. Resident 19's 5/24/24 Dental Care Plan revealed the following: -The resident had upper and lower dentures. -Staff were to provide the resident with oral hygiene supplies and assist with oral hygiene if she/he was too weak. -Staff were to assist with proper storage and clean the resident's dentures daily. A Social Services Quarterly assessment dated [DATE] indicated the resident had moderately impaired cognition, had no dental status changes and continued to use her/his dentures. On 5/19/25 at 3:36 PM Resident 19 was observed in bed without dentures in place. On 5/21/25 at 9:36 AM Staff 12 (CNA) stated Resident 19 had not worn her/his dentures for at least a year. Resident 19's denture case was observed on the counter next to her/his bedroom sink. Staff 12 opened the case, and the resident's dentures were observed in a clear fluid and the dentures were covered with black debris. When asked why the resident no longer wore her/his dentures, Staff 12 stated they did not fit. On 5/21/25 at 10:03 AM Staff 11 (CNA) stated the resident had not worn her/his dentures for a few months. Staff 11 stated the dentures caused the resident pain and he reported the concern to a nurse approximately two months ago. On 5/21/25 at 3:20 PM Staff 15 (LPN) stated she was unaware of any dental concerns for Resident 19 and was unsure if the resident wore dentures. On 5/22/25 at 10:43 AM Resident 19 was observed without top and bottom dentures in place. The resident stated the dentures needed to be adjusted. On 5/23/25 at 8:56 AM Staff 4 (Social Services Director) stated she was responsible for arranging dental services for residents with dental needs, including dentures. Staff 4 stated she was unaware of any concerns regarding Resident 19's dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/25 at 9:11 AM Staff 3 (RNCM) stated staff were expected to report concerns regarding resident dentures to Staff 4 so dental services could be scheduled. Staff 3 stated she was unaware of reported concerns regarding Resident 19's dentures or she/he no longer wore dentures. Staff 4 acknowledged an appointment for dental services should had been initiated for Resident 19.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47005 Based on observation, interview and record review it was determined the facility failed to ensure kitchen staff wore appropriate hair restraints during meal preparation and tray line for 1 of 1 facility kitchen reviewed for sanitation. This placed residents at risk for unsanitary foods and food-borne illness. Findings include: Review of the US FDA Food Code 2022 revealed: -Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food. On 5/19/25 at 9:10 AM on the initial kitchen tour observed Staff 10 (Dietary Manager) had facial hair and was observed putting breakfast items and cleaning the kitchen counters without a beard restraint in place. On 5/22/25 at 11:40 AM, Staff 10 was observed without a beard restraint while preparing lunch meals, taking food temperatures, and plating food. On 5/22/25 at 1:04 PM Staff 10 stated he expected his staff to follow hygiene protocols and wear hair restraints while working in the kitchen. Staff 10 stated he had offered beard restraints in past, but had never worn one himself. On 5/22/25 at 1:18 PM Staff 1 (Administrator) stated she expected the dietary staff to follow hygiene procedures and wear hair restraints including a beard restraint when working in the kitchen.