

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  Marquis Wilsonville Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  30900 SW Parkway Avenue Wilsonville, OR 97070	

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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34702</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from unnecessary bowel medication for 1 of 3 sampled residents (#3) reviewed for medication. This placed residents at risk for adverse medication side effects. Findings include:</p> <p>Resident 3 admitted to the facility on [DATE] with diagnoses including stroke and post hospital procedure for intestinal obstruction.</p> <p>The 4/16/24 hospital orders indicated Resident 3 was to receive loperamide 2 mg (antidiarrheal medication) two capsules twice daily and one capsule every six hours as needed for diarrhea.</p> <p>The 4/17/24 order indicated Resident 3 was to receive Miralax powder (laxative medication) once daily for bowel care. Hold for loose stools.</p> <p>The 4/2024 MARs indicated Resident 3 received Miralax once daily from 4/17/24 through 4/29/24.</p> <p>Resident 3's bowel records indicated the following dates when she/he had loose or watery stools on one or more occasions:</p> <p>-4/17/24</p> <p>-4/18/24</p> <p>-4/19/24</p> <p>-4/21/24</p> <p>-4/23/24</p> <p>-4/24/24</p> <p>-4/27/24</p> <p>-4/28/24</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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/7/24 at 12:08 PM Staff 2 (DNS) stated Resident 3 admitted with loperamide orders. Miralax was added for constipation and staff were to hold the Miralax for loose stools. Staff 2 acknowledged Resident 3 received an antidiarrheal medication in addition to a laxative and the resident had loose stools on the identified dates.</p>