STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385266	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Wilsonville Post Acute Rehab	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 39632 Based on interview and record review it was determined the facility failed to develop a comprehensive, person-centered care plan for 1 of 1 sampled resident (#27) reviewed for ADLs. This placed residents at risk for unmet bathing, grooming and vision needs. Findings include: Resident 27 was admitted to the facility in 9/2024 with diagnoses including Alzheimer's disease and macular degeneration (vision impairment). a. Resident 27's 9/15/24 Admission MDS indicated the resident wore glasses and it was very important to read. The vision CAA, completed by Staff 5 (Social Services) indicated the following: - ensure glasses were clean and appropriately worn. Resident 27's 9/2024 Care Plan did not include a focus, goals or interventions related to her/his vision and the use of glasses. On 12/17/24 at 1:27 PM, 1:47 PM and 2:01 PM Staff 10 (CNA), Staff 11 (CNA) and Staff 12 (RN) stated they referred to the Care Plan to determine Resident 27's care needs. Staff 10, Staff 11 and Staff 12 stated they were not sure if Resident 27 wore glasses. On 12/18/24 at 11:22 AM Staff 5 stated her role included building the Care Plan to reflect vision needs. Staff 5 acknowledged the Care Plan did not include information regarding Resident 27's use of glasses. On 12/18/24 at 1:41 PM Staff 2 (DNS) was notified of the findings of this investigation and acknowledged Resident 27's Care Plan lacked a focus, goal and interventions related to the resident's vision needs. b. Resident 27's 9/15/24 Admission MDS indicated the resident required moderate staff assistance for personal hygiene and grooming. Resident 27's 11/14/24 Behavior Assessment indicated the following: (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- resident has mixed incontinence of bowel and incontinent of bladder - refuses cares - refuses staff attempts with hygiene. Resident refuses care from staff - takes multiple approaches before resident accepts cares. Resident 27's 11/19/24 - 12/15/24 Bath/Shower Task Flowsheet revealed the resident refused seven of seven bathing opportunities and did not receive a bath or shower. Resident 27's 11/25/24 Bathing and Personal hygiene Care Plan included the following interventions: - constant supervision with physical assist combing hair, brushing teeth, shaving, washing/drying face, hands and perineum; - one person to provide physical assist with bathing. The Care Plan did not include person centered interventions related to refusals of personal hygiene and grooming care. On 12/18/24 at 10:54 AM Staff 3 (LPN Resident Care Manager) reviewed Resident 27's Care Plan. Staff 3 acknowledged the Care Plan did not reflect Resident 27's refusal of hygiene and grooming care and lacked person centered interventions.

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NAME OF PROVIDER OR SUPPLIER Marquis Wilsonville Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 30900 SW Parkway Avenue Wilsonville, OR 97070	

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 39632 Based on interview and record review it was determined the facility failed to ensure the resident was involved and informed of the discharge plan for 1 of 2 sampled residents (#30) reviewed for care planning. This placed residents at risk for being uninformed about their discharge plan. Findings include: Resident 30 was admitted to the facility in 11/2024 with diagnoses including Raynaud's syndrome (disorder of the blood vessels). Resident 30's 9/15/24 Admission MDS indicated the resident was cognitively intact. Resident 30's 11/8/24 Discharge Care Plan, created by Staff 5 (Social Services) indicated the following: - Anticipated discharge plan is to: HLOC, prefers AFH No other information was found on the Care Plan related to Resident 30's discharge plan. Resident 30's 11/14/24 Care Conference indicated the discharge plan was reviewed with the resident and the projected discharge date was 12/11/24. On 12/16/24 at 11:44 AM Resident 30 stated she/he did not feel included in the discharge plan. The resident stated nobody ever talked to me or kept her/him informed about where or when she/he would be discharged from the facility. The resident said it was confusing because various staff relayed conflicting information about what day she/he was leaving the facility. The resident stated there was no discussion after the 12/11/24 projected discharge date and she/he felt very stressed. On 12/17/24 at 2:24 PM Resident 30's health record revealed no evidence of communication to indicate the resident was informed and updated regarding the 12/11/24 projected discharge date . No documentation was found regarding discharge planning other than the 11/14/24 Care Conference. On 12/18/24 at 10:50 AM Staff 4 (RNCM) stated each of us randomly have conversations with Resident 30 related to the discharge plan but the conversations were not documented. Staff 4 stated Staff 5 was primarily responsible for discharge planning. On 12/18/24 at 11:30 AM Staff 5 was asked to explain the process to ensure residents were included in their discharge plan and Staff 5 stated she talked to the residents weekly. Staff 5 reviewed Resident 30's health record and acknowledged there was no documentation of the weekly conversations. Staff 5 stated she was not consistent with documentation and acknowledged there was no documentation to indicate Resident 30 was informed and updated regarding the discharge plan since the 11/14/24 Care Conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 39632 Based on observation, interview and record review it was determined the facility failed to provide adequate bathing and grooming for 1 of 1 sampled resident (#27) reviewed for ADLs. This placed residents at risk for poor hygiene and grooming. Findings include: Resident 27 was admitted to the facility in 9/2024 with diagnoses including Alzheimer's disease, restlessness and agitation. Resident 27's 9/15/24 Admission MDS indicated the resident had severe cognitive impairment and required moderate staff assistance for personal hygiene and grooming. Resident 27's 9/2024 Bathing and Personal Hygiene Care Plan indicated the resident required staff assistance and constant supervision for bathing and personal hygiene and the resident's hygiene needs will be met. Resident 27's Bath/Shower Task Flowsheet revealed the resident did not receive a bath/shower for 27 days between 11/19/24 through 12/15/24. On 12/16/24 at 4:11 PM Witness 2 (Family) stated the resident used to be clean shaven all the time. On 12/16/24 at 10:33 AM and 12/17/24 at 1:15 PM Resident 27 had long, unkempt facial hair. Resident 27 was unable to answer questions related to her/his bathing, hygiene and grooming. On 12/17/24 at 1:27 PM and 2:01 PM Staff 10 (CNA) and Staff 11 (CNA) stated Resident 27 required a moderate amount of staff assistance for bathing, hygiene and grooming and stated the resident frequently refused bathing, hygiene and grooming. Staff 10 and Staff 11 stated if a resident refused care, the process included to redirect the resident and offer care several additional times. Staff stated if those approaches were unsuccessful, they reported the refusals to the nurse. On 12/17/24 at 1:47 PM Staff 12 (RN) stated if a resident refused care, CNAs reported the refusal to the nurse and it was documented in the health record. Staff 12 stated the resident was put on alert charting and monitored for behaviors, and staff were to make additional attempts to provide bathing, hygiene and grooming. Staff 12 stated she was unaware if Resident 27 refused bathing, hygiene and grooming and was not notified of any refusals of care. Resident 27's health record revealed no documentation related to refusals of bathing, hygiene or grooming, no alert charting and no evidence the resident was offered alternative bathing, hygiene or grooming opportunities between 11/19/24 and 12/15/24. On 12/18/24 at 1:41 PM Staff 2 (DNS) was notified of the findings of this investigation and acknowledged the resident did not receive bathing, hygiene or grooming care for 27 days. Staff 2 stated if a resident refused bathing, hygiene and grooming everyday, attempts should be made to modify the approach and plan of care to ensure bathing, hygiene and grooming was provided.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 39632 Based on observation, interview and record review it was determined the facility failed to ensure residents received vision services for 1 of 1 sampled resident (#27) reviewed for vision. This placed residents at risk for unmet vision needs. Findings include: Resident 27 was admitted to the facility in 9/2024 with diagnoses including macular degeneration (vision impairment). Resident 27's 9/15/24 Admission MDS indicated the resident wore glasses and it was very important to read. The vision CAA, completed by Staff 5 (Social Services) indicated the following: - Ensure glasses were clean and appropriately worn; - Resident has macular degeneration that impairs vision. [Resident] has a visual deficit and has glasses [she/he] does not use because [she/he] needs a new glasses prescription. [Resident stated] They aren't the correct prescription any way. Resident 27's health record revealed no evidence the facility facilitated vision services to ensure the resident was assessed for glasses and had the appropriate prescription. 12/16/24 at 4:14 PM Witness 2 (Family) stated Resident 27 required prescription glasses to see and when they visited, Resident 27 was not wearing her/his glasses. On 12/16/24 at 10:33 AM and 12/17/24 at 1:15 PM Resident 27 did not wear glasses. Resident 27 was unable to answer questions related to the use of glasses. On 12/18/24 at 3:51 PM Staff 5 stated she completed the 9/15/24 Vision CAA and thought she followed up on the resident's need for an appointment and new prescription glasses. Staff 5 reviewed Resident 27's health record and acknowledged she did not follow up regarding Resident 27's need for a vision assessment and appointment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50927 Based on interview and record review it was determined the facility failed to ensure pharmacy recommendations were followed up on for 1 of 5 sampled residents (#10) reviewed for medications. This placed residents at risk for adverse medication reactions. Findings include: Resident 10 was admitted to the facility in 2/2024 with diagnoses including depression and hypotension. Monthly pharmacist reviews of Resident 10's medication regimen revealed the following: -On 11/4/24 the pharmacist recommendation advised the prescriber to discontinue PRN haloperidol after 14 days (11/15/24). If necessary, write a new order x 14 days only after direct examination and documentation is completed. No response from the provider was found in Resident 10's health care record or provided by the facility. -On 11/4/24 the pharmacist recommendation advised the prescriber to provide the following rationale and duration: It is appropriate for PRN lorazepam to be extended beyond 14 days. Medication necessary to help with comfort as resident transitions towards end-of-life. Continue order for 6 months at which time continued use will be re-evaluated. No response from the provider was found in Resident 10's health care record until 12/5/24. On 12/19/24 at 4:00 PM Staff 3 (Resident Care Manager) confirmed the facility did not receive a response from Resident 10's provider regarding the 11/2024 pharmacist's recommendations until 12/5/24.