STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385279	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Tualatin Post Acute Rehab	19945 SW Boones Ferry Road Tualatin, OR 97062

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 36494 Based on interview and record review the facility failed to notify a resident's representative of a fall for 1 of 3 sampled residents (#1) reviewed for falls. This placed resident representatives at risk for being uninformed of resident accidents. Findings include: Resident 1 was admitted to the facility in 11/2023 with diagnoses including BPH (benign prostatic hyperplasia) and depression. Resident 1's Admission Record revealed Witness 15 (Family Member) was Resident 1's resident representative and emergency contact. No information was found in the clinical record to indicate Witness 15 signed paperwork as Resident 1's resident representative. On 6/5/24 at 12:48 PM Witness 15 stated Resident 1 fell at the facility on the morning of 12/3/23, and no one from the facility contacted Witness 15 regarding the incident. On 6/6/24 at 11:22 AM Staff 12 (LPN) stated she did not contact the family after Resident 1's fall because the resident was her/his own representative. On 6/6/24 at 12:47 PM Staff 4 (RNCM) stated Witness 15 should have been notified of the fall if Witness 15 was Resident 1's resident representative. On 6/7/24 at 10:15 AM Staff 3 (Admissions Director) stated she reviewed all admission paperwork with residents and family members. Staff 3 stated Witness 15 was Resident 1's resident representative. Staff 3 stated Resident 1 appointed Witness 15 to be her/his resident representative. Staff 3 stated she was present and there was a verbal agreement, but no paperwork signed during the admission process. Staff 3 stated she ensured the information was entered into the resident's medical record. On 6/7/24 at 10:52 AM Staff 2 (Administrator) acknowledged Witness 15 was Resident 1's representative and should have been notified regarding Resident 1's fall on 12/3/23. Refer to F689

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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NAME OF PROVIDER OR SUPPLIER: Marquis Tualatin Post Acute Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 19945 SW Boones Ferry Road Tualatin, OR 97062	

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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. 36494 Based on interview and record review it was determined the facility failed to ensure residents received care plan interventions for safe transfer and failed to ensure residents were monitored after a fall for 1 of 3 sampled residents (#1) reviewed for accidents. This placed residents at risk for latent injury. Findings include: Resident 1 was admitted to the facility in 11/2023 with diagnoses including BPH (benign prostatic hyperplasia) and depression. A review of the resident's care plan, dated 11/28/23, indicated Resident 1 required a two-person mechanical lift with transfers, wore non skid socks when out of bed, and the call light was to be within reach. a. A Fall/Post Fall Assessment and Investigation dated 12/3/24 revealed the following: -At 9:45 AM, Resident 1 was found on the floor next to the left side of her/his bed by Staff 12 (LPN). -The resident was previously sitting in her/his wheelchair and Staff 12 heard Resident 1 calling for help. -Resident 1 stated she/he became dizzy and fell forward out of the wheelchair. -The resident was toileted at 7:00 AM and was last observed at 8:30 AM while eating breakfast. The resident received her/his medications, and was offered fluids. -Staff 12 assessed the resident, who denied pain and her/his range of motion was within normal limits. The resident was injured with a bruise to the left side of her/his forehead. A neurological (assessing mental status and level of consciousness, pupillary response, motor strength, sensation, and gait) assessment was completed. The resident was assisted back into bed. No abuse or neglect was identified. -The investigation indicated Resident 1 was her/his own responsible party and was marked as no requirement to notify others. The Resident Representative section was blank. No information was found in Resident 1's clinical record to indicate she/he was monitored for latent injuries after the 12/3/23 fall. On 6/5/24 at 12:48 PM Witness 15 (Family Member) stated Resident 1 fell at the facility on the morning of 12/3/23. Witness 15 stated the facility did not monitor the resident appropriately prior to and after the resident fell out of her/his wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 11:22 AM Staff 12 stated she recalled when Resident 1 fell out of her/his wheelchair due to dizziness on 12/3/24. Staff 12 stated the resident sustained a bruise to her/his left forehead. Staff 12 stated she did not contact Witness 15 but notified the physician. Staff 12 stated Resident 1 was to be placed on alert charting to monitor for latent injury, but she did not recall if this occurred or not. On 6/6/24 at 12:47 PM Staff 4 (RNCM) stated she expected staff to place Resident 1 on 72-hour alert charting to monitor for latent injury. Staff 4 acknowledged and verified Resident 1 was not placed on alert charting from her/his fall on 12/3/24. On 6/7/24 at 10:52 AM Staff 2 (Administrator) acknowledged Resident 1 was not placed on alert charting after the fall on 12/3/24 to monitor for latent injuries b. On 6/5/24 at 12:48 PM, Witness 15 (Family Member) stated an incident occurred during an evening visit with Resident 1 on an unknown date. Witness 15 stated he observed two CNAs using a mechanical lift to transfer Resident 1. The CNA operating the lift was in a hurry, which caused the mechanical lift to strike Resident 1's head as the two CNAs lowered the resident into the wheelchair. Witness 15 stated the CNA guiding Resident 1's legs yelled at the other CNA to slow down, but the CNA operating the mechanical lift did not listen, which resulted in Resident 1's head being struck. Witness 15 stated after the CNAs placed Resident 1 in the wheelchair, both CNAs left the room without assessing the resident for potential injuries. Witness 15 stated Resident 1 was not a complainer, and did not call out in pain, but staff should have reported the incident to a nurse so the resident could be evaluated. On 6/5/24 at 4:33 PM Staff 10 (Agency CNA) stated she recalled transferring Resident 1 with another CNA using a mechanical lift. The CNA operating the lift was not paying attention and moving quickly. Staff 10 stated she was guiding Resident 1's feet and hollered at the other CNA to slow down, but the CNA operating the lift did not listen, and the lift struck Resident 1 in the head. Staff 10 stated she asked Resident 1 if she/he was hurt, and the resident said she/he was not hurt. Staff 10 stated she did not report the incident to a nurse and acknowledged the incident should have been reported to rule out an injury. On 6/6/24 at 12:47 PM Staff 4 (RNCM) stated she was unaware Resident 1 was struck in the head while being transferred with a mechanical lift. Staff 4 stated she expected staff to report any incident involving a potential injury to the charge nurse right away to ensure an assessment was completed. On 6/7/24 at 10:52 AM Staff 2 (Administrator) acknowledged the findings and stated CNAs were to report any potential injury with a mechanical lift to a charge nurse so the resident could be assessed appropriately.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 36494 Based on interview and record review it was determined the facility failed to provide appropriate catheter care for a resident's urinary catheter for 1 of 3 sampled residents (#1) reviewed for catheter care. This placed residents at increased risk for infection. Findings include: Resident 1 was admitted to the facility in 11/2023 with diagnoses including BPH (benign prostatic hyperplasia) and hematuria (blood in the urine). A Nursing Admission Assessment, dated 11/28/23 at 9:19 AM, revealed Resident 1 admitted due to urosepsis (a urinary tract infection which spreads to the kidneys) with hematuria. The resident had a urinary catheter with a large amount of hematuria present. The resident was at risk for functional incontinence related to weakness, impaired mobility, and dependence on staff to meet mobility and toileting needs. Resident 1 was care planned for staff assistance with toileting, used a large brief, received daily urinary catheter care, and skilled therapy services to promote toileting safety and mobility. A review of the resident's care plan, dated 11/28/23, indicated the presence of a urinary catheter. The care plan indicated staff were to provide catheter care with soap and water every day and were to monitor for signs and symptoms of infection. A 12/2/23 Skilled Nursing Progress Note revealed Resident 1 was alert but disoriented, was able to follow simple instructions and cooperative with care and services. The urinary catheter was in place with adequate output. Hematuria was noted around the genital area. A 12/5/23 Progress Note revealed at the beginning of evening shift Resident 1 had a temperature of 99.3. The resident's temperature was taken again at 6:00 PM and was 102.2. Tylenol was given, and the physician was called. Due to the resident's current symptoms and history, it was decided the resident would be sent out to the hospital for further evaluation. Resident 1 had a urinary analysis collected and the results were a high white blood cell count. A Lab Results Report dated 12/5/23 revealed Resident 1's white blood cell count was elevated. On 12/7/23 a public complaint was received from Witness 16 (Complainant), alleging Resident 1 arrived at the hospital on 12/5/23 with a catheter and UTI. When the catheter was removed, it was leaking and caused pain, accompanied by dark cloudy urine. Additionally, there were also sores on the resident's genitalia. On 6/5/24 and 6/6/24 attempts were made to reach Witness 16 but were unsuccessful. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 12:48 PM Witness 15 (Family Member) stated the facility did not provide adequate catheter care for Resident 1. Witness 15 stated the resident was sent to the hospital on 12/5/23, and hospital staff observed and reported to Witness 15 that Resident 1 had blood and discharge coming from the genitalia. Witness 15 stated hospital staff reported Resident 1 had erosion at the catheter entry point which indicated possible improper positioning of the catheter. Witness 15 stated the situation was gruesome and upsetting. On 6/5/24 at 2:32 PM Staff 9 (CNA) stated Resident 1 required daily catheter care to maintain cleanliness and prevent infection. Staff 9 expressed concerns that residents did not receive appropriate catheter care in 11/2023 and 12/2023. Staff 9 stated agency staff did not consistently provide appropriate ADL care. On 6/5/24 at 4:33 PM Staff 10 (Agency CNA) stated Resident 1 had a catheter, and she emptied the catheter bag at the end of her shift but did not provide any other care related to the catheter, such as cleaning the catheter or providing peri care. On 6/6/24 at 10:26 AM Staff 11 (CNA) stated Resident 1 was alert and oriented but had some baseline confusion. Staff 11 stated she provided catheter care and the resident's catheter, was uncomfortable and caused tugging. Staff 11 recalled the resident had redness and blood coming out of the tip of the resident's genitalia a few times and she informed the nurse. Staff 11 stated a skin protective barrier was applied to the tender, red area. Staff 11 stated catheter care was to be performed once daily using soap and water. On 6/6/24 at 10:46 AM Staff 7 (LPN) stated Resident 1 required catheter care provided by CNA staff. Staff 7 stated catheter care was not always provided adequately and depended on which CNAs were working. Staff 7 expressed concerns about a lack of appropriate catheter care in 11/2023 and 12/2023 due to staff unfamiliarity with the residents. On 6/6/24 at 11:48 AM Staff 8 (LPN) stated Resident 1 was confused at baseline and admitted with a catheter and hematuria. Staff 8 stated catheter care was provided during day shift. Staff 8 stated she assumed CNAs provided catheter care and expected CNAs to review Resident 1's care plan prior to starting their shift. Staff 8 recalled Resident 1 had dried blood on the tip of her/his genitalia, and the area was red but did not appear painful. Staff 8 stated she did not remove the stat lock (stabilization device and support) to the catheter but provided the resident with a little more slack in the tubing that inserted into her/his genitalia. Staff 8 stated the resident was not alert enough to respond to questions. On 6/6/24 at 12:47 PM Staff 4 (RNCM) acknowledged Resident 1 was not provided with appropriate catheter care. Staff 4 stated staff were expected to provide appropriate catheter care to residents and to report any new concerns to herself or the physician. On 6/7/24 at 10:27 AM Staff 5 (Regional Nurse Consultant) and at 10:52 AM Staff 2 (Administrator) stated all CNA staff were expected to know and provide daily catheter care once daily with soap and water. Staff 5 stated if staff were unable to provide catheter care, they were to report to the charge nurse to ensure residents' received appropriate catheter care. Staff 2 acknowledged Resident 1 was not provided with appropriate catheter care.