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	02/28/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830 Based on interview and record review it was determined the facility failed to prevent misappropriation of financial resources by Staff 7 (Former Agency CNA) for 1 of 1 sampled resident (#145) reviewed for misappropriation of property. This placed residents at risk for misuse of personal funds. Findings include: The facility's 5/2010 Misappropriation of Property- Lost Items policy specified misappropriation of resident property as the patterned or deliberate exploitation of a resident's belongings or money without the resident's consent. Resident 145 was admitted to the facility in 10/2024 with diagnoses including right femur fracture (a break in the thigh bone). The 10/16/24 Admission MDS indicated Resident 145 was cognitively intact. Resident 145 discharged from the facility on 11/2/24. A 12/4/24 FRI indicated on 12/4/24 Witness 1 (Family) reported to Staff 1 (Administrator) a fraudulent check was written from Resident 145's check book while a resident at the facility. The check was made out to Staff 7 while she/he was a resident On 12/4/24 Staff 1 contacted local law enforcement, and a report was made. It was noted Staff 7 would not return to work at the facility. The 12/10/24 facility investigation indicated Staff 7 was assigned as Resident 145's CNA on 11/3/24, 11/7/24, 11/8/24, and 11/9/24. Staff 7 was asked not to return to the facility on [DATE] due to declining to take care of residents in her assigned section. On 11/9/24 the fraudulent check was cashed, and it was noted Resident 145's signature was forged. The Oregon Board of Nursing was notified of Staff 7's misconduct and law enforcement was also notified. The facility investigation concluded that abuse occurred but was limited to Resident 145. On 2/26/25 at 1:57 PM Witness 1 stated the fraudulent check was written to Staff 7 for $2,000. Witness 1 stated the signature on the check was not Resident 145's. On 2/26/25, 2/27/25 and 2/28/25 attempts to contact Staff 7 were unsuccessful. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 9:53 AM Resident 145 stated she/he first became aware of the fraudulent check when the monthly bank statement was received. Resident 145 stated her/his check book was kept in the nightstand drawer next to the bed at the facility. Resident 145 stated she/he never offered staff money, staff never asked her/him for money and there were no pre-signed checks in the check book. Resident 145 stated she/he did not sign the check made out to Staff 7 for $2,000. On 2/28/25 at 9:14 AM and 10:55 AM Staff 1 acknowledged Resident 145's misappropriation of funds and indicated there were no other reports of misappropriation of property.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830 Based on interview and record review it was determined the facility failed to thoroughly investigate alleged misappropriation of property for 1 of 1 sampled resident (#145) reviewed for abuse. This placed residents at risk for misuse of personal funds. Findings include: The facility's 5/2010 Misappropriation of Property- Lost Items policy specified when an incident of misappropriation of resident property was reported, the administrator would appoint a staff member to investigate the incident. The investigation would consist of the following: -An interview with the resident. -An interview with the employee(s) accused of taking the resident's property. -A review of the resident's personal inventory record to determine if missing items were recorded on the report. -Interviews with staff members (on all shifts as applicable) having contact with the resident. Resident 145 was admitted to the facility in 10/2024 with diagnoses including right femur fracture (a break in the thigh bone). The 10/16/24 Admission MDS indicated Resident 145 was cognitively intact. Resident 145 discharged from the facility on 11/2/24. A 12/4/24 FRI indicated on 12/4/24 Witness 1 (Family) reported to Staff 1 (Administrator) a fraudulent check was written from Resident 145's check book while she/he resided at the facility. The check was made out to Staff 7 (Former Agency CNA). On 12/4/24 Staff 1 contacted local law enforcement, and a report was made. It was noted Staff 7 would not return to work at the facility. The 12/10/24 facility investigation indicated Staff 7 was assigned as Resident 145's CNA on 11/3/24, 11/7/24, 11/8/24, and 11/9/24. Staff 7 was asked not to return to the facility on [DATE] due to declining to take care of residents in her assigned section. On 11/9/24 the fraudulent check was cashed, and it was noted Resident 145's signature was forged. The Oregon Board of Nursing was notified of Staff 7's misconduct, law enforcement was also notified. The facility investigation concluded that abuse occurred but was limited to Resident 145. The facility's investigation included an interview with Staff 8 (CNA) and Staff 9 (CNA) who worked with Staff 7 on several shifts and two residents who resided on the same hallway as Resident 145. Review of the facility's 12/10/24 investigation revealed it was not thorough and did not address the following: -An interview with the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An interview with the employee(s) accused of taking the resident's property. -A review of the resident's personal inventory record to determine if missing items were recorded on the report. -Interviews with staff members (on all shifts as applicable) having contact with the resident. On 2/28/25 at 9:14 AM and 10:55 AM Staff 1 acknowledged Resident 145 and Staff 7 were not interviewed as part of the investigation. Staff 1 stated Resident 145's personal inventory record could not be found and staff members who had contact with Resident 145 were not interviewed. Staff 1 verified the facility investigation was not thorough.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48830 Based on observation, interview and record review it was determined the facility failed to ensure medications and biologicals were secured for 1 of 4 medication and treatment carts reviewed for safe medication storage. This placed residents at risk for unauthorized access to medications. Findings include: The facility's 5/2010 Security of Medication Cart Policy specified the following: -The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. -The medication cart must be securely locked at all times when out of the nurse's view. a. On 2/26/25 at 11:38 AM, the medication cart adjacent to the nursing station entered A-hall was unlocked and unattended. At 11:40 AM Staff 6 (RN) entered the A-hallway with a different medication and treatment cart. As Staff 6 passed by the unlocked and unattended cart she was observed to push in the lock on the cart to secure it and kept walking. Staff 6 went to a resident's room nearby and Staff 5 (RN) was observed to exit that same resident's room. During an interview with Staff 5 and Staff 6 on 2/26/25 at 11:42 AM Staff 5 stated he did leave the medication and treatment cart unlocked and it should have been locked when he was out of sight of the cart. Staff 6 confirmed she locked the cart as she walked by. b. On 2/26/25 at 12:29 PM, the medication cart adjacent to the nursing station on the A-hall was unlocked and unattended. At 12:31 PM Staff 5 approached the medication and treatment cart, and was observed to have pushed in the lock on the cart to secure it. On 2/26/25 at 12:32 PM Staff 5 acknowledged he left the medication and treatment cart unlocked and was out of sight. On 2/26/25 at 12:45 PM Staff 2 (DNS) was notified the medication and treatment cart on the A-hall was left unlocked and unattended with the contents accessible to unauthorized staff and residents on two separate occasions by the same staff member. Staff 2 acknowledged the cart was to be locked when unattended.