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	05/22/2026

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

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to properly disinfect a shared glucometer between resident uses for 1 of 5 sampled residents (#1) reviewed for infection control during CBG checks. This failure, determined to be an Immediate Jeopardy situation, placed all residents who required CBG checks at significant risk for bloodborne illness. Findings include: The undated facility Glucometer Disinfection Policy indicated to disinfect after each individual patient use with EPA disinfectant wipes.A 2017 Evencare G2 Glucometer Manufacturer Manual indicated, Disinfect common use glucometers with the use of approved disinfectant wipes. The glucometer was to be wiped with the disinfecting wipe and left wet for two minutes to ensure disinfection. Resident 1 was admitted to the facility in 3/2023 with diagnoses including Hepatitis B (a highly contagious viral infection that can lead to severe liver damage and cancer).The 3/2026 and 4/2026 MARs indicated Resident 1 received CBG monitoring before meals and at bedtime from varying staff members including Staff 6 (RN). On 5/19/26 at 12:12 PM, Staff 6 was observed to obtain a CBG for Resident 31. Staff 6 returned to the medication cart, wiped the glucometer with an alcohol pad wipe, which was not an EPA-approved disinfecting wipe, and placed the glucometer back inside the cart. Staff 6 stated she always cleaned the glucometers with an alcohol pad wipe after use, and she believed other staff cleaned it the same way. Staff 6 stated her work assignments rotated and she sometimes worked in all three halls of the facility. On 5/19/26 at 3:30 PM, Staff 2 (DNS) stated she expected staff to use EPA-approved disinfecting wipes to clean the glucometers after each resident use. Staff 2 acknowledged using alcohol pad wipes to disinfect glucometers was not sufficient. A facility census provided by Staff 2, dated 5/18/26, indicated there were 13 residents who received daily CBG monitoring, including Resident 1. On 5/19/26 at 4:30 PM, the facility administrative staff, including Staff 1 (Administrator), and Staff 2 were notified that the deficient practice related to the failure to properly disinfect the common use glucometer constituted an Immediate Jeopardy (IJ) situation and were provided a copy of the IJ Template. On 5/20/26 at 2:49 PM, an acceptable plan to remove the IJ situation was submitted by the facility. The plan indicated the facility would implement the following actions: - The three additional residents on the same hallway as Resident 1 that have CBGs being monitored have the potential to be impacted by this deficient practice.- All glucometers in the facility have been disinfected using MicroKill 1 disinfectant versus the alcohol pad wipes with the isopropyl 70%. - The three additional residents on the same hallway, providers have been notified for lab test monitoring PRN. - All licensed nurses on shift have been educated on appropriate disinfecting of the glucometer. - All licensed nurses on shift were re-educated on cleaning of the glucometer during shift huddle. - All licensed nurses not on site will be contacted via phone to be inserviced on appropriate disinfecting of the glucometer by the end of the day on 5/19/26. - Any nurses on vacation or leave of absence will be in serviced prior to their first shift back. - DNS or designee will audit twice daily for one week to ensure appropriate disinfection has occurred, After one week audits will be daily for one week. Then weekly for four weeks to ensure ongoing compliance, - QAPI meeting will be held on 5/19/26 with DNS, Administrator, Medical Director and [NAME] VP Clinical Services to determine root cause analysis and ensure ongoing compliance. From 5/19/26 through 5/20/26 the IJ removal (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	plan was verified as implemented by the survey team. No additional concerns related to the IJ situation were noted. The immediacy was removed on 5/20/26 after verification of completion of the IJ removal plan. Following removal of the immediacy, remaining noncompliance remained with no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy.

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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. Based on observation and interview it was determined the facility failed to store food in a sanitary manner for 1 of 1 resident refrigerator reviewed for sanitary food storage and handling. This placed residents at risk for food-borne illness and contamination. Findings include:On 5/18/26 at 10:46 AM during the initial tour of the facility's dining room and kitchenette the following was observed in the communal freezer:-An opened ice cream bar, uncovered, not labeled or dated.-A small ice cream container covered with a plastic lid, not labeled or dated.-Dried brown substance smudged on the sides of the freezer wall.-Spilled substance stuck on the bottom of the freezer shelf.On 5/18/26 Staff 1 (Administrator) and Staff 17 (Dietary Manager) observed the items with the surveyor and indicated the items in the freezer needed to be thrown away and the spilled substances needed to be cleaned.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to provide personal hygiene for 1 of 2 sampled residents (#26) reviewed for ADLs. This placed residents at risk for poor hygiene. Findings include: Resident 26 was admitted to the facility in 10/2022 with diagnoses including Parkinson's.The 2022 [NAME] Standards of Care indicated the following: -Staff were required to shave residents as needed. A 10/2022 Care Plan indicated Resident 26 required supervision with cueing and assistance during shaving. A 4/27/26 Quarterly MDS indicated Resident 26 had a BIMS score of 15 indicating she/he was cognitively intact. The 5/18/26 and 5/21/26 Medical Record indicated Staff 8 (CNA) and Staff 9 (CNA) provided assistance to complete personal hygiene.During random observations from 5/18/26 through 5/21/26 from 8:00 AM to 4:00 PM, Resident 9's beard was unkempt. Resident 9's beard was overgrown with gray and brown hairs. On 5/20/26 at 9:18 AM, Resident 26 stated staff did not offer to assist her/him during personal hygiene after she/he showered on 5/18/26. Resident 26 stated she/he asked staff on multiple occasions to assist with shaving and staff were not available. Resident 26 stated she/he had a right-hand tremor and shaving herself/himself was challenging. On 5/21/26 at 12:47 PM, Resident 26 stated staff did not offer to assist her/him with shaving after she/he showered. Resident 26 touched her/his chin hair and stated she/he wanted to shave. Resident 26 stated she/he did not feel good because staff did not have time to help shave her/him. On 5/21/26 at 1:26 PM, Staff 8 stated Resident 26 had occasional tremors to her/his hands. Staff 8 stated Resident 26 required staff to set up and help her/him shave. Staff 8 stated she did not offer to shave Resident 26 because she did not notice overgrown hair on her/his face.On 5/21/26 at 1:32 PM, Staff 9 stated Resident 26 had occasional tremors to her/his hand. Staff 9 stated Resident 26 required minimal assistance to complete personal hygiene including shaving. Staff 9 stated she did not have time to shave Resident 26 on 5/18/26 and she did not tell staff. On 5/22/26 at 1:43 PM, Staff 5 (RNCM) stated Resident 26 required supervision with cueing and assistance during shaving. Staff 5 stated she expected staff to offer to shave residents after showers. Staff 5 stated she was unaware staff were not completing personal hygiene after showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to follow physician orders for 2 of 6 sampled residents (#s 18 and 31) reviewed for dialysis and medications. This placed residents at risk for worsening medical conditions. Findings include:1. Resident 18 was admitted to the facility in 5/2026 with diagnoses including kidney failure and diabetes. A review of Resident 18's current physician orders indicated the following medication and treatment: -Aspirin daily for heart health. -Vitamin B12 for a daily supplement. -CBGs were to be taken in the morning and at bedtime. Resident 18's 5/2026 MAR revealed the resident did not receive Aspirin, Vitamin B12 or have her/his CBGs checked on the mornings of 5/9, 5/12, 5/14, 5/16, 5/19 and 5/20. On 5/21/26 at 10:23 AM Staff 6 (RN) stated Resident 18 had dialysis early in the morning on Tuesday, Thursday and Saturday. Staff 6 stated on the days the resident had dialysis she/he did not receive her/his morning medications and CBG checks due to being out of the facility. On 5/21/26 at 12:17 PM Staff 3 (RNCM) acknowledged Resident 18 did not receive medication and treatment as the physician ordered on mornings the resident was sent out to dialysis. 2. Resident 31 was readmitted to the facility on [DATE] with diagnoses including deafness and hydronephrosis with renal and ureter obstruction (a condition where one or more kidneys swell because urine cannot drain properly into the bladder). The 4/19/26 admission MDS indicated Resident 31 had a BIMS score of zero which indicated the resident was not cognitively intact. The MDS indicated Resident 31 had a history of vomiting. On 5/18/26 at 12:47 PM, Witness 2 (Family Member) stated Resident 31 had daily nausea and vomiting. Witness 2 stated Resident 31 was a poor historian and communication was difficult. Witness 2 stated nausea and vomiting symptoms were not managed consistently and Resident 31 was not able to keep food or drinks down. Witness 2 stated Resident 31 was uncomfortable every day. On 5/19/26 at 10:52 AM, Resident 31 was observed in her/his room vomiting. Resident 31 frowned and pointed to her/his belly and throat. Resident 31 screamed and curled back into fetal position. The 5/19/26 MAR indicated Staff 6 (RN) administered PRN ondansetron (anti-nausea medication) to Resident 31 for nausea symptoms at 4:52 PM (seven hours later). Staff reassessed effectiveness at 8:41 PM and Resident 31's nausea was not resolved and medication was ineffective. On 5/22/26 at 8:15 AM and 8:22 AM, Resident 31 was observed coughing and gagging after she/he finished eating breakfast. When Staff 10 approached the resident, Resident 31 pointed to her/his belly and grimaced indicating she/he was painful. Resident 31 pointed to her/his throat and opened her/his mouth. Staff 10 (CNA) approached the resident and she wheeled the resident back into her/his room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No information was found in the resident's clinical record to indicate Resident 31 was offered PRN medication for the resident's nausea when the resident returned to her/his room. On 5/22/26 at 10:12 AM, Resident 31 was observed in her/his room pointing to her/his belly, lower back and gestured indicating she/he was painful. The resident was observed coughing and gagging. Resident 31 grabbed a bucket and vomited. Resident 31 returned to bed and was dry heaving. The 5/22/26 MAR indicated Staff 11 (LPN) administered PRN ondansetron to Resident 31 for nausea and vomiting symptoms at 10:24 AM. On 5/22/26 at 10:32 AM, Staff 10 stated Resident 31 was deaf and communication was difficult. Staff 10 stated Resident 31 had nausea, vomiting and lower back pain since admission. Staff 10 stated she did not report to the nurse when Resident 31 pointed to her/his belly and throat after breakfast. On 5/22/26 at 11:20 AM, Staff 11 stated Resident 31 was deaf and communication was difficult. Staff 11 stated Resident 31 depended on staff to assess and address her/his daily needs. Staff 12 stated he was unaware Resident 31 had daily nausea and vomiting. Staff 12 stated he was unaware Resident 31 was nauseous after breakfast. Staff 11 stated Resident 31's nausea and vomiting PRN medication was not consistently administered. On 5/22/26 at 11:29 AM, Staff 6 stated Resident 31 had daily nausea and vomiting since admission. Staff 6 stated management of nausea and vomiting was not consistent. Staff 6 stated she was Resident 31's nurse during the morning of 5/19/26 and acknowledged she did not provide PRN nausea medication to Resident 31. On 5/22/26 at 12:27 PM, Staff 3 (RN Resident Care Manager) stated staff did not consistently offer PRN ondansetron to address Resident 31's nausea and vomiting.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review it was determined the facility failed to ensure staff assisted residents with use of a prescribed boot to prevent a potential decrease in ROM or mobility for 1 of 1 sampled resident (#5) reviewed for ADLs. This placed residents at risk for loss of ROM and mobility. Findings include:Resident 5 was admitted to the facility in 2/2026 with diagnoses including a stroke.Resident 5's 2/15/26 admission MDS indicated the resident had severe cognitive impairment and a range of motion impairment on her/his lower extremity.Resident 5's revised 4/27/26 Care Plan revealed the resident required a contracture boot to be placed on her/his right foot for two hours on and two hours off.Random observations between 5/18/26 from 10:00 AM and 5/21/26 at 9:05 AM revealed Resident 5's contracture boot sat on the chair next to the resident's bed and revealed no instances of Resident 5 with the contracture boot on her/his foot.On 5/19/26 at 12:28 AM Witness 3 (Family Member) stated Resident 5 was supposed to have a support boot placed onto her/his right foot. Witness 3 stated staff failed to place the boot regularly and she was concerned the resident would develop a contracture.On 5/19/26 at 1:24 PM Staff 14 (CNA) stated Resident 5 was required to wear a splint on her/his right arm to prevent swelling and was unable to provide information related to the resident's contracture boot.On 5/20/26 at 9:45 AM Staff 15 (CNA) stated Resident 5 was unable to move her/his upper and lower extremities on her/his right side due to a severe stroke and was unable to speak to any interventions in place to prevent range of motion decline.On 5/20/26 at 11:46 AM Staff 13 (Rehab Director) stated Resident 5 admitted to the facility with a therapy evaluation which indicated the resident benefited from the boot to prevent the development of a contracture. Staff 13 stated it was important for Resident 5 to continue and wear the boot to prevent a right food drop or foot inversion.On 5/22/26 at 12:48 PM Staff 2 (DNS) stated it was important for Resident 5 to have her/his contracture boot placed and acknowledged staff did not regularly assist the resident to use the contracture boot.