STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38A026	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Autumn Hills Memory Care	6630 SW Beaverton-Hillsdale Hwy Portland, OR 97225

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42270 Based on interview and record review it was determined the facility failed to honor the resident's right to be free from physical abuse from other residents for 1 of 6 sampled residents (#2) reviewed for abuse. This placed residents at risk for physical abuse. Findings include: Resident 2 admitted to the facility in 3/2025 with diagnoses including Alzheimer's disease. Resident 2's 3/17/25 Admission MDS revealed she/he had a BIMS of 9, which indicated moderate cognitive impairment. Resident 3 admitted to the facility in 8/2023 with diagnoses including dementia. Resident 3's 2/24/25 Quarterly MDS revealed she/he had a BIMS of 12, which indicated moderate cognitive impairment. An 4/19/25 facility Investigation Summary and Conclusion revealed on the morning of 4/19/25 Resident 2 and Resident 3 were in their shared room asleep when Resident 2 woke up and turned on the overhead light. Resident 3 woke up and became angry, swore at Resident 2, and pushed her/him back onto her/his bed. Resident 3 then went to the common television room to complain about the overhead light being on. The facility moved the residents to different rooms. Neither resident was injured during the incident. Resident 2's 4/19/25 Resident to Resident Event Assessment revealed Resident 2 was interviewed after the incident and stated Resident 3 cursed at her/him when the bedroom light was turned on. Resident 2 stated Resident 3 then shoved her/him hard onto the bed and attacked her/him because she/he turned on the light. Resident 2 stated the incident scared her/him and she/he complained of left shoulder pain later in the day. Resident 3's 4/19/25 Resident to Resident Event Assessment revealed Resident 3 was interviewed after the incident and stated Resident 2 stood over her/his bed yelling and Resident 3 then pushed Resident 2 onto her/his bed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 7:51 AM Staff 6 (CNA) stated she worked on 4/19/25 and recalled the incident between Resident 2 and Resident 3. Staff 6 stated she found Resident 3 screaming about pushing Resident 2 because she/he turned the light on. Resident 2 was very scared and wanted to be out of the shared room. The two residents were then separated. On 5/15/25 at 1:25 PM Resident 3 stated she/he and Resident 2 had many issues because they shared a room and Resident 2 turned the light on every night. Resident 3 stated on 4/19/25 Resident 2 woke her/him up when she/he turned the light on. Resident 3 stated the two residents then went back and forth turning the light on and off until she/he shoved Resident 2 onto the bed. On 5/15/25 at 1:32 PM Resident 2 stated Resident 3 was upset because she/he said the light was in her/his face and then Resident 3 shoved Resident 2 down on the bed. Resident 2 stated she/he was afraid at the time but felt safe now because the facility moved her/him out of the shared room. Resident 2 stated she/he felt abused by Resident 3 and no longer interacted with her/him. On 5/15/25 at 4:51 PM Staff 11 (LPN) stated on 4/19/25 she was called to the room Resident 2 and Resident 3 shared. Staff 11 stated Resident 3 was upset and stated she/he pushed Resident 2 because Resident 2 turned on the light. Staff 11 stated Resident 2 was upset and reported being scared. On 5/15/25 at 2:50 PM Staff 2 (DNS) stated she investigated the 4/19/25 event and concluded the incident met the definition of abuse. The deficient practice was identified as Past Noncompliance based on the following: On 4/19/25, the deficient practice was identified by the facility and was corrected when the facility implemented the following to prevent further incidents of resident to resident abuse: 1. Resident 2 and Resident 3 were separated, 2. The facility implemented auditing through alert charting, 3. The facility reviewed and updated Resident 2 and Resident 3's care plans.