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	02/27/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review it was determined the facility failed to provide functional call lights for 3 of 3 sampled residents (#s 20, 21, and 26) reviewed for accommodation of needs. This placed residents at risk for not being able to call for assistance. Findings include: The facility's 1/2016 Assessment for Ability to Make Use of Electric Call System policy instructed facility staff to assess residents for call light use at admission and when a significant change occurred. The policy instructed facility staff to document identified call light safety risks in the resident's record.a. Resident 20 was admitted to the facility in 2/2024 with diagnoses including unspecified dementia.Resident 20's 8/30/25 revised care plan revealed she/he used a pressure sensitive call light pad. b. Resident 21 was admitted to the facility in 8/2025 with diagnoses including unspecified dementia and repeated falls.Resident 21's 2/14/26 revised care plan did not include information related to call light use. c. Resident 26 was admitted to the facility in 6/2019 with diagnoses including Alzheimer's disease.Resident 26's 8/18/23 Call Light Safety Assessment revealed the resident was aware and able to use a call light. On 2/23/26 at 10:26 AM, 2/24/26 at 8:25 AM, and 2/25/26 at 9:25 AM Residents 20, Resident 21, and Resident 26 were observed to have their call lights unplugged from the call light box in their rooms, and no alternative means to call for assistance.On 2/24/26 at 2:21 PM Staff 9 (CNA) stated residents were to have functional call lights and stated she did not know why Resident 20, Resident 21, and Resident 26 did not have functional call lights. She stated staff were always present in the unit and the residents without functional call lights were either independent with care or sought out staff when they needed assistance. On 2/25/26 at 10:24 AM Staff 7 (RN) stated every resident was supposed to have a functional call light. She stated she did not know the reason Resident 20, Resident 21, or Resident 26 did not have functional call lights. Staff 7 stated the staff did regular rounding to check on residents and were close enough to hear residents yelling for help.On 2/25/26 at 11:00 AM Staff 8 (Maintenance Director) stated he was notified of new admission call light placement needs before a resident was admitted to the facility and stated he was notified through an internal facility system for broken or missing call lights. Staff 8 stated he painted Resident 26's room on 2/22/26, removed the call light, and forgot to replace it. He stated Resident 21 should have a functional call light but could not identify why one was not in place. Staff 8 stated Resident 20's call light was removed when he replaced the batteries in the call light box on 2/24/26. Staff 8 acknowledged the lack of functional call lights for Residents 20, 21 and 26. On 2/26/26 at 1:32 PM Staff 2 (DNS) acknowledged functional call lights were required for all residents.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to provide adequate monitoring of antipsychotic medication use for 1 of 5 sampled residents (#16) reviewed for medications. This placed residents at risk for adverse side effects of antipsychotic medication. Findings include: Resident 16 was admitted to the facility on [DATE] with diagnoses including vascular dementia with agitation and depression.A 1/12/26 physician order revealed Resident 16 was prescribed quetiapine 75 MG (an antipsychotic medication) twice daily.A review of Resident 16's medical record revealed no indication an Abnormal Involuntary Movement Scale (AIMS) (used to identify if symptoms/side effects of psychoactive medication use were present) assessment was completed.On 2/26/26 at 3:58 PM Staff 2 (RNCM/DNS/IP) stated Resident 16 was already on an antipsychotic medication upon admission, so her understanding was Resident 16 did not require an AIMS completed until six months after admission.On 2/26/26 at 4:10 PM Staff 11 (Regional RN Consultant) stated Resident 16 required an AIMS assessment completed upon admission and every six months as the resident received antipsychotic medication. Staff 11 confirmed Resident 16 did not have an AIMS completed upon admission.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure assistance was provided with dressing and personal hygiene for 1 of 3 sampled residents (#9) reviewed for ADLs. This placed residents at risk for poor hygiene. Findings include:Resident 9 was admitted to the facility on [DATE] with diagnoses including delusional disorders.The 2022 [NAME] Standards of Care indicated the following:-Staff were required to change residents' clothing each day. -Staff were required to shave residents as needed. The 10/2025 Care Plan indicated the following:-Resident 9 required supervision and assistance to complete dressing.-Ensure clothing and footwear was clean.-Provide assistance with dressing after resident attempted each step. -Pick out a couple appropriate outfits and offer me choices.The Kardex indicated Resident 9 required constant supervision with cueing and minimal physical assistance during shaving.The 11/2025 Quarterly MDS indicated Resident 9 had a BIMS score of 6 which indicated the resident was cognitively severely impaired. The 2/25/26 Medical Record indicated Staff 9 (CNA) provided assistance to complete personal hygiene. From 2/24/26 through 2/26/26 from 8:00 AM to 4:00 PM, Resident 9 was observed wearing the same blue sweater, sweatpants and socks. Resident 9's beard was long with white and brown hair. Resident 9's mustache was thick and overgrown down to her/his top lip. On 2/24/26 at 1:27 PM, Resident 9 acknowledged her/his long beard and stated she/he had not shaved. Resident 9 stated she/he allowed staff to shave her/his beard. On 2/25/26 at 9:11 AM, Resident 9 was resting in bed. Resident 9 stated he was unsure when she/he last changed clothes or shaved her/his beard. On 2/25/26 at 1:30 PM, Resident 9 was observed leaving the facility for an outing and was wearing the same clothes she/he wore all day the previous day. On 2/26/26 at 9:44 AM, Staff 9 stated Resident 9 was independent and cooperative. Staff 9 stated Resident 9 required staff to set up personal hygiene supplies including clothes daily. Staff 9 stated she was unable to shower her/him or set up supplies because she was busy with other residents. On 2/26/26 at 10:01 AM Staff 7 (RN) stated Resident 9 was redirectable, cooperative and did not refuse care. Staff 7 stated Resident 9 was able to complete daily personal hygiene independently. Staff 7 stated she expected staff to set up personal hygiene supplies, including clothing daily. Staff 7 stated staff notified her if residents refused care. Staff 7 stated Resident 9 did not refuse personal hygiene assistance during the week. On 2/26/26 at 11:23 AM, Staff 2 (RNCM/DNS/IP) stated she monitored the medical electronic system to ensure personal hygiene tasks were completed and followed up with staff if incomplete documentation was observed. Staff 2 stated Resident 9 was cooperative and redirectable and did not refuse care. Staff 2 stated she felt disturbed to hear Resident 9 was wearing the same clothes for the last three days because she/he was redirectable and completed personal hygiene.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review it was determined the facility failed to provide residents with a written bed hold notification, including reserved bed hold payment, at the time of transfer to the hospital for 1 of 1 sampled resident (#5) reviewed for hospitalization. This placed residents at risk for lack of knowledge regarding their choices and potential financial responsibilities. Findings include:Resident 5 was admitted to the facility in 4/2024 with diagnoses including diabetes and heart disease.A review of Resident 5's clinical record revealed she/he was transferred to the hospital on the following dates: 11/19/25, 11/29/25, 12/2/25, 12/21/25, and 2/10/26. No evidence was found in Resident 5's clinical record to indicate written notice of the facility's bed hold policy was provided to the resident or her/his representative when she/he was transferred to the hospital.On 2/26/26 at 3:47 PM Staff 10 (LPN Resident Care Manager) stated upon transfer to the hospital, the charge nurse was to open an assessment in the resident's medical record and provide the resident with a bed hold notification.On 2/27/26 at 10:01 AM Staff 2 (RNCM/DNS/IP) confirmed a written bed hold notification was not provided to Resident 5 or her/his representative at the time of transfer to the hospital on the specified dates.