STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385077	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Springfield	1333 N. 1st Street Springfield, OR 97477

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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. 38139 Based on interview and record review it was determined the facility failed to protect residents' rights to be free from misappropriation of property by staff for 4 of 4 sampled residents (#101, 102, 103 and 104) reviewed for misappropriation of property. Findings include: 1. Resident 101 was admitted to the facility in 2024, with diagnoses including cancer of the colon and frontal lobe of the brain. A Police Department Incident/Investigation Report dated 10/28/24, indicated the department received a report from the facility regarding possible theft of narcotic medication. On the night of 10/23/24 Staff 3 (Agency LPN) oversaw resident medications on the facility's South Hall and a resident complained to day shift staff she/he did not receive her/his narcotic pain medication and was in pain. Several other residents also complained about not getting their medications. Staff 2 (DNS) began an investigation and multiple medication administration and documentation discrepancies were found specifically with narcotic medications. All the concerns involved Staff 3. A progress note by Staff 4 on 10/24/2024 at 3:07 AM, indicated she called the pharmacy requesting verification of any remaining for Resident 101's oxycodone. Staff 4 called the on-call nurse practitioner to request an order for the resident's medication to ensure Resident 101 was medicated prior to the resident leaving for her/his chemotherapy treatment in the morning. Staff 4 called the pharmacy for authorization to pull the medication from the facility's Pyxis machine (computerized medication dispensing system that helps clinicians safely and efficiently provide the correct medications to the right patients at the right time), then gave the medication to Staff 3 to administer. Staff 4 did not watch Staff 3 administer the medication. The pharmacy Med Bank Report from the Pyxis machine for the early morning hours of 10/24/24 contained the following electronically generated medication information: On 10/24/24 at 4:42 AM, oxycodone was removed for Resident 101 by Staff 4. Resident 101's 10/2024 MAR indicated the resident was administered the following dose of medication on 10/24/24: Oxycodone narcotic pain medication by Staff 3 at 4:00 AM. Staff 3 documented she administered Resident 101's oxycodone medication at 4:00 AM but the medication was not pulled from the Pyxis machine until 4:42 AM. Staff 3 could not have administered the medication before it was available. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/3/24 at 12:53 PM Resident 101, stated on 10/23/24 around 11:00 PM she/he requested pain medication and Staff 3 (LPN) told her/him there was no oxycodone (narcotic pain medication) for her/him in the medication cart and she gave her/him Tylenol and a muscle relaxant. Staff 3 told the resident she would let the day shift nurse figure out the oxycodone medication issue in the morning. The resident stated she/he knew the oxycodone medication; it was a smaller pill than her/his other medications and helped her/him to sleep. The Tylenol and muscle relaxant the nurse administered did not help her/him to sleep. The resident stated she/he had increased pain from not receiving the oxycodone and could not sleep that night. On 12/4/24 at 8:30 AM, Staff 4 (LPN) stated two CNAs came to tell her a resident was asking for pain medication and had been asking for quite a while. Staff 4 went to check with Staff 3 to see why she did not give the resident her/his oxycodone medication. Staff 3 stated she gave the resident Tylenol. Staff 4 then told Staff 3 the resident needed her/his oxycodone and if there was no current oxycodone on the cart, she just had to call the on-call physician and get a script called into the pharmacy. Staff 3 told her she was going on a break. Staff 4 stated she told Staff 3 it was neglect to leave a resident in pain. Staff 4 decided she needed to step in to assist the resident and she called the on-call physician, got an order, called the pharmacy for an authorization, pulled the medication from the Pyxis machine (Emergency Kit), and gave the medication to Staff 3 to administer to the resident. In the morning the resident stated she/he did not get the medication and Staff 3 had told her/him she was going to leave it for the day shift to figure out. On 12/4/24 at 8:50 AM, Staff 5 (CNA) stated the evening of 10/23/24 the facility had a scheduled downtime for the computer system from 11:00 PM to 1:15 AM. She reminded Staff 3 about the downtime so Staff 3 could check on her residents before the computer went down. Staff 5 stated Staff 3 did not do so and stated she was not going to look at the PRN sheet (for medications) until after the downtime. Staff 5 stated she had written down a PRN request for Resident 101 for oxycodone because the resident was very painful. When she answered the resident's call light at 1:30 AM the resident said Staff 3 had still not administered the oxycodone. Staff 5 stated she went to the nurse on the other hall to request assistance for the resident. On 12/5/24 at 8:24 AM, Staff 3 (LPN) stated she had computer issues on the evening shift of 10/23/24. Staff stated the computer system kept crashing and probably didn't save her documentation. She remembered Resident 101 had requested pain medication. She told the resident she was waiting for authorization from the pharmacy. Staff 3 stated she made a call to the on-call physician to get the order, then she had to call the pharmacy for an authorization. She said she got the authorization in the middle of the night but did not remember what time it arrived. Staff 3 stated she thought she gave Resident 101 Tylenol and maybe an ice pack. Then Staff 4 pulled the medication from the Pyxis machine and handed it to Staff 3 to administer. Staff 3 stated she thought it was normal for one nurse to just hand medication to another nurse. Staff 3 stated she signed the medication into the narcotic book. The On-Call Physician Log report for the facility indicated Staff 4 was the only person to make a call to the on-call telephone line on 10/24/24. Staff 3 claimed she had completed the steps necessary to get the resident's pain medication but the record showed she did not call the on-call physician for an order for Resident 101 or any other resident. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/5/24 at 9:50 AM, Staff 2 (DNS) stated when Staff 3 told the resident she/he would have to wait for pain medication until the day shift nurse came in to figure it out, she was not following standard nursing practice. Staff 2 stated Staff 3 reported she had made the arrangements to get the medication from the Pyxis machine for the resident but Staff 3 did not. Staff 2 also stated other staff reported they were unable to find Staff 3 at numerous times during the shift, she took a lot of breaks, and she met with someone in a van out in the parking lot during the night. Staff also found two medication cups Staff 3 labeled for residents in the trash of a bathroom that was not located in an area where Staff 3 should have disposed of them. Staff 2 acknowledged the oxycodone for Resident 101 was documented as administered by Staff 3 before it was available to administer. Staff 2 stated she had reported the concerns to OSBN and Law Enforcement. 2. Resident 102 was admitted to the facility in 2024, with diagnoses including end stage renal disease and traumatic amputation of the right lower leg. Resident 102 was alert and oriented. A Police Department Incident/Investigation Report dated 10/28/24, indicated they received a report from the facility regarding possible theft of narcotic medication. Multiple medication administration and documentation discrepancies were found, specifically with narcotic medications, and all the concerns involved Staff 3 (Agency LPN). The pharmacy Med Bank Report from the Pyxis machine (computerized medication dispensing system that helps clinicians safely and efficiently provide the correct medications to the right patients at the right time) for the early morning hours of 10/24/24 contained the following medication information: On 10/24/24 at 3:53 AM, oxycodone was removed by Staff 4. Resident 102's 10/2024 MAR indicated the resident was administered the following dose of medication on 10/24/24: oxycodone narcotic pain medication by Staff 3 at 3:48 AM. Staff 3 documented she administered Resident 102's oxycodone medication at 3:48 AM but the medication was not pulled from the Pyxis machine until 3:53 AM. Staff 3 could not have administered the medication before it was available. On 12/4/24 at 10:04 AM, Resident 102 stated no one gave her/him oxycodone on the night shift of 10/23/24 to 10/24/24. Resident 102 stated the bandage came off her/his wound and the linens rubbing on her/his stump was so painful it was a 9 out of 10 on the pain scale. The resident was adamant no one gave her/him any oxycodone. The nurse gave him Tylenol only and it did not help very much. The resident stated they gave her/him something stronger starting the next day. On 12/5/24 at 8:24 AM, Staff 3 stated they had to pull the oxycodone for the resident from the Pyxis machine. Staff 3 stated Staff 4 pulled it and she administered it. Staff 3 stated she put it in a med cup with the Tylenol, the oxycodone was small and the room was dark so maybe the resident didn't see it. On 12/5/24 at 9:50 AM, Staff 2 (DNS) stated Resident 102 was very alert and oriented. It was not remotely possible that she/he would have missed the oxycodone medication in the cup. Staff 2 acknowledged Staff 3 documented she had administered the medication before it was even available. Staff 2 added Staff 3 documented she gave the medication at 3:48 AM and then documented it was effective at 3:53 AM, which is not an adequate amount of time to determine effectiveness. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 103 was admitted to the facility in 2019, with diagnoses including metabolic encephalopathy (neurological disorder that occurs when the brain is affected by a chemical imbalance in the blood), and Alzheimer's disease. A Police Department Incident/Investigation Report dated 10/28/24, indicated they received a report from the facility regarding possible theft of narcotic medication. Multiple medication administration and documentation discrepancies were found specifically with narcotic medications and all the concerns involved Staff 3 (LPN). Resident 103's 10/24/2024 MAR indicated at 3:00 AM Resident 103 was marked as sleeping so did not receive her/his scheduled dose of Tramadol (narcotic pain medication). The 10/2024 Narcotic Log book page #043 for Resident 103 indicated one dose of Tramadol was pulled by Staff 3 at 3:00 AM. The page did not contain any documentation of what happened to the medication when it was not administered to the resident because she/he was sleeping. The medication should have been destroyed by Staff 3 with the assist of another nurse to verify destruction. The dose of Tramadol was not found by staff. A pharmacy Disposal of Controlled Drugs in a Long-Term Care facility report dated 10/2024 for Resident 103 verified the dose of Tramadol pulled by Staff 3 on 10/24/24 at 3:00 AM had not been destroyed. On 12/5/24 at 8:24 AM, Staff 3 (LPN) stated if she pulled the medication, but the resident was sleeping, maybe she administered it later or taped it in the book? There was no documentation found in the medical record to indicate what happened to the medication. On 12/5/24 at 9:07 AM, Staff 2 (DNS) stated the Narcotic Log showed Staff 3 pulled the medication at 3:00 AM but she also charted the resident was sleeping at 3:00 AM so she did not administer the medication. Standard nursing practice indicated if a nurse pulled a medication, that nurse should administer the medication, or the nurse should destroy the medication with a second nurse as a witness. Staff 2 stated you do not save the medication for later and you do not tape the medication in the narcotic book. No evidence was found to show the medication, which had not been administered, was destroyed and Staff 2 stated they did not find the medication in the facility. 4. Resident 104 was admitted to the facility in 2024, with diagnoses including heart failure, respiratory failure, and peripheral vascular disease (disorder of the blood which can cause pain, cramping, aching, or burning in the legs and feet.) A Police Department Incident/Investigation Report dated 10/28/24, indicated they received a report from the facility regarding possible theft of narcotic medication. Multiple medication administration and documentation discrepancies were found, specifically with narcotic medications, and all the concerns involved Staff 3 (Agency LPN). Resident 104's 10/2024 MAR indicated on 10/24/24 at 12:09 AM, Staff 3 administered a dose of oxycodone to the resident and the medication was effective. Then at 1:00 AM (50 minutes later) Staff 3 documented she administered a dose of Tylenol. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Both doses were documented as administered on the MAR during times the one-to-one sitter stated the resident was asleep. A written statement by Staff 7 (LPN) indicated when she heard report on 10/24/24 at 6:30 AM she asked if Resident 104 had received any pain medication on the night shift and was told by the CNA the resident slept all night. On 12/4/24 at 1:08 PM, Staff 6 (CNA) stated he was the one-to-one sitter with Resident 104 on the night shift of 10/23/24. He worked from 10 PM to 6 AM. He never saw Staff 3 administer any medications to Resident 104 and the resident slept through the night. Staff 6 stated the nurse did come by the hall twice but was only looking for the other nurse and Staff 3 never entered the resident's room. On 12/5/24 at 8:24 AM, Staff 3 stated she administered medication one time during the night shift to Resident 104. She stated she administered the medication while the female CNA went to the bathroom. She also stated the female CNA was on the shorter side and had short, cropped hair. Staff 3 concluded she was in the room with her (female CNA). On 12/5/24 at 9:07 AM, Staff 2 (DNS) acknowledged Staff 3 documented she administered pain medication to Resident 104 but there was a male caregiver assigned as a one-to-one sitter to Resident 104 who reported the nurse never entered the resident's room during the night shift and the resident slept through the night.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38139 Based on interviews and record reviews it was determined the facility failed to report a reasonable suspicion of a crime to the State Survey Agency for 4 of 4 sampled residents (#s 101,102, 103 and 104) reviewed for misappropriation of property. This placed residents at risk for further misappropriation of property and incomplete investigations. Findings include: A Police Department Incident/Investigation Report dated 10/28/24 indicated they received a report from the facility regarding possible theft of narcotic medication. A Complaint Form dated 10/23/24 at 10:00 PM to 10/24/24 at 6:00 AM (the night shift) submitted by the facility to the Oregon State Board of Nursing indicated a possible diversion of medications had occurred. On the morning of 10/24/24 the medication aides reported several narcotics had been incorrectly signed out and medications were signed out of the narcotic book but not documented as administered on the eMAR (electronic MAR) by Staff 3 (LPN). There were discrepancies in Staff 3's charting of narcotics. Interviews with residents determined some residents had only received Tylenol for pain relief and not their oxycodone medications. The residents were alert and oriented. An investigation was completed and found other discrepancies. All the concerns found were linked to Staff 3. A report was filed with Law Enforcement. On 12/03/24 at 12:15 PM Staff 2 (DNS) indicated they did not report the concerns to the State Survey Agency, but had reported to OSBN and the local law enforcement agency. Staff 2 stated she felt there may not be enough evidence to prove the diversion of medications. Staff 2 stated she did have concerns with Staff 3's handling of narcotic medications and there were multiple documentation issues which raised her suspicions which included when Staff 3 stated she gave PRN Tylenol at the same time she gave PRN narcotic pain medication. Normally you would administer the Tylenol, and if it was not effective, then administer the narcotic. It did not make sense to give both medications at the same time. On 12/4/24 at 3:17 PM Staff 1 (Administrator) and Staff 2 acknowledged they should have reported to the State Survey Agency.