

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/01/2024
NAME OF PROVIDER OR SUPPLIER  Avamere at Three Fountains		STREET ADDRESS, CITY, STATE, ZIP CODE 835 Crater Lake Avenue Medford, OR 97504	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38139</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from misappropriation of their narcotic medications for 3 of 3 sampled residents (#s 103, 104 and 105) reviewed for drug diversion. This placed residents at risk for unmet medication care needs. Findings include:</p> <p>On [DATE], the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined three incidents of misappropriation of resident's narcotic medication were found.</p> <p>An interview on [DATE], with Staff 1 (Administrator) and Staff 2 (DNS) revealed the facility's plan of correction included the following:</p> <ul style="list-style-type: none"> <li>-Staff 7 (RCM/LPN) began Investigation immediately upon being informed of the missing medications and Staff 8 was put on administrative leave.</li> <li>-All staff with access to medication carts were drug screened.</li> <li>-All discarded medications were destroyed.</li> <li>-Access to medication carts was minimized during the investigation.</li> <li>-All narcotic books (ledgers) were audited.</li> <li>-No residents were negatively impacted by the missing medications.</li> <li>-Missing medications were reported to physician, State Agency, and Law Enforcement Agency on [DATE] and [DATE].</li> <li>-Staff 8 (LPN) was suspended pending the investigation and later terminated.</li> <li>-Staff education completed for all CMAs and LPNs on fully completing each section of the narcotic books and on the narcotic destruction process. Training included: Narcotic Books and Page Transfer In-service, Controlled Substance Log Book, Shift Audit Record, Example Documentation, Pharmacy: Pulling Controlled Medications from the Cubex Machine.</li> </ul> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Any narcotic discrepancies are to be reported immediately to nurse management.</p> <p>-Carts checked at least weekly for discontinued narcotics.</p> <p>-DNS or designee to audit all med carts weekly for narcotic destruction needs.</p> <p>-DNS or designee will audit up to three narcotic books weekly for accuracy for four weeks, then monthly for three months, until substantial compliance was met.</p> <p>On [DATE] at 3:42 PM Staff 1 and Staff 2 were notified of past non-compliance.</p> <p>1. Resident 103 was admitted to the facility in ,d+[DATE], with diagnoses including palliative care (end of life) and chronic pain.</p> <p>An Incident Report dated [DATE] indicated Staff 3 (CMA) reported to Staff 4 (RCM/LPN) her concern of missing narcotics during her narcotics count. Staff 4 reviewed the medication destruction logs and found the missing medication card of oxycodone (a narcotic pain medication) had been signed to another page in the facility's Narcotic Book with a different medication and resident name on the card. A search was conducted but staff were unable to find the missing medication card.</p> <p>A review of the facility's Narcotic Log Book indicated a page was initiated on [DATE] for Resident 103's narcotic pain medication (oxycodone). Resident 103 received her/his medication twice on [DATE] and once on [DATE]. The bottom of the page indicated the balance of the medications were transferred to Unit I, Book 80, page 125, with a balance of 27 tablets. The new page was backed dated [DATE]. The balance transfer date on the page was prior to the dates any medication was administered. The signature on the page was identified by the facility as a forgery.</p> <p>A facility investigation document dated [DATE] by Staff 2 (DNS), indicated the day shift CMA remembered counting a page (in the narcotic book) for a recently deceased resident but the corresponding card of narcotics was not in the medication cart. The card was unable to be located by staff. The destruction logs were checked by the RCM and she found the page of oxycodone had been signed as if transferred to another page in the narcotic book but that page had a different medication and resident's name on it. On [DATE], two additional cards of oxycodone were identified to be missing from another cart. An investigation for narcotic diversion was started. Law enforcement and the state agency were notified.</p> <p>On [DATE] at 2:15 PM, Staff 1 (Administrator) acknowledged the misappropriation of medications had occurred.</p> <p>2. Resident 104 was admitted to the facility in ,d+[DATE], with diagnoses including fractured leg and chronic pain.</p> <p>An Incident Report dated [DATE], indicated Staff 5 (CMA) notified a RCM she felt there were missing narcotics from her medication cart. Staff 5 went page by page through the narcotic book and identified missing medication. One missing card of oxycodone was found previously for another resident and two missing cards of oxycodone were found to be missing for Resident 104.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Narcotic Log Book indicated pages were initiated on [DATE] and [DATE] for Resident 104's PRN narcotic pain medication (oxycodone). Resident 104 received her/his last medication from the [DATE] card on [DATE] and from the [DATE] card on [DATE]. The bottom of the page indicated the balance of the medications were transferred to other books and pages which were found to already have entries for other residents. The balance transfer dates on the pages were illegible. The signature on the page was identified by the facility as a forgery.</p> <p>The facility investigation dated [DATE], indicated the resident received her/his last dose of the medication on [DATE] when she/he had out patient surgery. The RCM found two pages of the narcotic book had been signed as if the medications were transferred to another page but those pages had different medications and residents on them. The two cards in question were not accounted for anywhere in the books or in the facility. The missing medications identified were noted to be discontinued medications. An audit of the narcotic books in use showed no further concerns. Law enforcement and the state agency were notified.</p> <p>On [DATE] at 2:15 PM, Staff 1 (Administrator) confirmed the misappropriation of medications had occurred.</p> <p>3. Resident 105 was admitted to the facility in ,d+[DATE] with diagnoses including traumatic brain injury and neuralgia (shock-like pain that follows the path of a nerve).</p> <p>A Facility reported incident dated [DATE], indicated a CMA reported a narcotic was signed out of the narcotic book after a medication count was completed and after the keys were handed off. The signature in the book appeared to be forged. No adverse effects were noted as a result of the potential misappropriation. The facility determined a dose of Resident 105's oxycodone was signed out of the narcotic book at 6:20 PM on [DATE] and was not documented on the eMAR, and the resident did not receive the dose of the medication at 6:20 PM. Staff were unable to find the missing dose of medication and misappropriation of property was not ruled out. Facility staff noted the medication was similar, and the signature on the narcotic book page resembled the signatures identified in their previous drug diversion investigation opened on [DATE].</p> <p>On [DATE] at 2:15 PM, Staff 1 (Administrator) acknowledged the misappropriation of medication had occurred. Staff 1 also stated Staff 8 was the only one with keys to the cart during the timeframe the narcotic went missing.</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38139</p> <p>Based on interview and record review it was determined the facility failed to ensure Staff 6 (LPN) adhered to professional standards for 1 of 7 sampled residents (#101) reviewed for significant medication error. As a result, Resident 101 experienced a decline in condition and required hospitalization for a drug overdose. Findings include:</p> <p>On 8/30/23 the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined Staff 6 failed to adhere to professional standards of practice for medication administration.</p> <p>An interview on 3/28/24, with Staff 1 (Administrator) and Staff 2 (DNS) revealed the facility's plan of correction included the following:</p> <ul style="list-style-type: none"> <li>-Staff education completed for all CMAs and LPNs on: Administering Medications Policy, 7 Rights of Medication Administration, 5 Ways to Identify Residents and medication pass audit.</li> <li>-DNS completed education with the responsible nurse.</li> <li>-DNS or designee will conduct random audits of CMAs or LNs weekly for completing the seven rights of medication administration and how to identify residents for four weeks, then at least monthly for three months.</li> </ul> <p>[NAME] 851 045 0050 Scope of Practice Standards for Licensed Practical Nurses indicated the following:</p> <ul style="list-style-type: none"> <li>(A) Implementing treatments and therapy, appropriate to the context of care, including, but not limited to, medication administration, nursing activities, nursing, medical and interdisciplinary orders; health teaching and health counseling.</li> <li>(c) Be knowledgeable of the professional nursing practice standards applicable to LPN practice and adhere to those standards.</li> </ul> <p>[NAME] 851 045 0070 Conduct Derogatory to the Standards of Nursing</p> <p>(4)Conduct related to communication:</p> <ul style="list-style-type: none"> <li>(a)Failure to accurately document nursing interventions and nursing practice implementation.</li> <li>(b)Failure to document nursing interventions and nursing practice implementation in a timely, accurate, thorough, and clear manner. This includes failing to document a late entry within a reasonable time period.</li> <li>(c)Entering inaccurate, incomplete, falsified, or altered documentation into a health record or agency records. This includes but is not limited to:</li> </ul> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Failing to communicate information regarding the client's status to other individuals who are authorized to receive information and have a need to know.</p> <p>(8)Conduct related to other federal or state statute or rule violations:</p> <p>(q) Failing to dispense or administer medications in a manner consistent with state and federal law.</p> <p>Resident 101 was readmitted to the facility in 8/2023 with diagnoses including recent placement of a cardiac pacemaker (implanted medical device that generates electrical pulses to chambers of the heart), respiratory failure and end stage kidney disease with dialysis (clinical purification of blood).</p> <p>A Facility Reported Incident indicated on the evening of 8/16/23, Resident 101 received ten medications prescribed for Resident 106. Resident 101 was administered the following medications:</p> <ul style="list-style-type: none"> <li>-Advair (a steroid medication),</li> <li>-Clozaril (an antipsychotic medication),</li> <li>-Olanzapine (an antipsychotic medication),</li> <li>-Metformin (an anti-diabetic medication),</li> <li>-D-Mannose (a UTI prevention medication),</li> <li>-Flomax (an alpha blocker medication),</li> <li>-Combivent (a beta 2-adrenergic agonist medication),</li> <li>-Tylenol (an analgesic),</li> <li>-Vitamin C and,</li> <li>-Systane eyedrops.</li> </ul> <p>The report indicated the medications was given by Staff 6 (LPN) just after 7:00 PM. The report indicated Staff 6 realized he had administered the wrong medications to Resident 101 and the resident had a decrease in her/his level of consciousness. The physician was notified and the resident was sent out to the hospital on 8/17/24 at 1:09 AM.</p> <p>A Hospital History and Physical dated 8/17/23, indicated on arrival the resident had an altered mental status related to an unintentional drug overdose. The plan was to address the acute encephalopathy (alteration of mental status due to systemic factors) due to the drug overdose. While at the nursing facility the resident was administered the following medications: metformin 2,000 mgs (an antidiabetic medication),</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>clozapine 175 mgs (an antipsychotic medication), Olanzapine 5 mgs (an antipsychotic medication) and seven other medications prescribed to another resident. The clinical impression included metformin and an antipsychotic overdose.</p> <p>On 3/29/24 at 8:15 AM, Staff 6 stated he gave Resident 101 ten medications prescribed for Resident 106. Staff 6 stated while giving Resident 101 the medications, she/he stated this was a lot of medications. Staff 6 stated he did not follow up on Resident 101's statement. Staff 6 stated it was a lapse in his practice for not verifying the correct resident before administering the medications. Staff 6 stated he realized later he had made the mistake. Staff 6 stated he also went back and gave Resident 101 her/his prescribed medications after being aware of his initial medication error. The resident received mirtazapine (an antidepressant medication), Eliquis (a blood thinner medication), vitamin D and artificial tears eye drops. Medication documentation indicated the resident received those medications at 8:30 PM which was after the 7:00 PM medication error and she/he was also administered nitroglycerin (heart medication) at 10:39 PM. Staff 6 stated, I should have checked with someone before giving her/him additional medications on top of the incorrect medications. I just used my nursing judgement.</p> <p>On 4/1/24 at 1:40 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed Staff 6 made a significant medication error, which resulted in Resident 101 being hospitalized . Staff 1 acknowledged Staff 6 did not follow protocol for the safe administration of medications and failed to contact the physician prior to administering additional medications to Resident 101. Staff 1 also confirmed Staff 6 failed to provide appropriate documentation in the medical record for the other resident who's medications were administered to Resident 101.</p> <p>Refer to F760</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>38139</p> <p>Based on interview and record review it was determined the facility failed to ensure the resident was free from a significant medication error for 1 of 3 sampled residents (#101) reviewed for medications. As a result, Resident 101 was hospitalized for a drug overdose. Findings include:</p> <p>On 8/30/23 the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined significant medication errors were found.</p> <p>An interview on 3/28/24, with Staff 1 (Administrator) and Staff 2 (DNS) revealed the facility's plan of correction included the following:</p> <ul style="list-style-type: none"> <li>-Staff education completed for all CMAs and LPNs on Administering Medications Policy, 7 Rights of Medication Administration, 5 Ways to Identify Residents and medication pass audit.</li> <li>-DNS completed Education with the responsible nurse.</li> <li>-DNS or designee will conduct random audits of CMAs or LNs weekly for completing seven rights of medication administration and how to identify residents for four weeks, then at least monthly for three months.</li> </ul> <p>Resident 101 was readmitted to the facility in 8/2023, with diagnoses including recent placement of a cardiac pacemaker (implanted medical device that generates electrical pulses to chambers of the heart), respiratory failure, and end stage kidney disease with dialysis (clinical purification of blood).</p> <p>A Facility Reported Incident indicated on the evening of 8/16/23, Resident 101 received ten medications prescribed for Resident 106. Resident 101 was administered the following medications:</p> <ul style="list-style-type: none"> <li>-Advair (a steroid medication),</li> <li>-Clozaril (an antipsychotic medication),</li> <li>-Olanzapine (an antipsychotic medication),</li> <li>-Metformin (an anti-diabetic medication),</li> <li>-D-Mannose (a UTI prevention medication),</li> <li>-Flomax (an alpha blocker medication),</li> <li>-Combivent (a beta 2-adrenergic agonist medication),</li> <li>-Tylenol (an analgesic medication),</li> <li>-Vitamin C and Systane eyedrops.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The report indicated the medications were given by Staff 6 (LPN) just after 7:00 PM. The report indicated Staff 6 realized he had administered the wrong medications to Resident 101 and the resident had a decrease in her/his level of consciousness. The physician was notified and the resident was sent out to the hospital on 8/17/24 at 1:09 AM.</p> <p>A Facility Discharge Summary dated 8/17/23, indicated the resident was transferred to the hospital after she/he was given medications belonging to another resident at the bedtime medication pass on 8/16/24. The diagnosis was accidental overdose. The resident's condition on discharge was noted as poor.</p> <p>A Hospital Emergency Department Triage Note dated 8/17/23 at 1:18 AM, indicated Resident 101 received her/his own prescribed medications as well as ten medications from another resident at the facility. The facility monitored and became concerned when the resident became A&amp;O x 0 (alert and oriented times zero or the lowest level of consciousness) when she/he was normally A&amp;O x 4 (alert and oriented to person, place, time, and event).</p> <p>A Hospital History and Physical dated 8/17/23, indicated on arrival the resident had an altered mental status related to an unintentional drug overdose. The plan was to address the acute encephalopathy (alteration of mental status due to systemic factors) due to the drug overdose. While at the nursing facility the resident was administered the following medications: metformin 2,000 mgs (an antidiabetic medication),</p> <p>clozapine 175 mgs (an antipsychotic medication), Olanzapine 5 mgs (an antipsychotic medication) and seven other medications prescribed to another resident. The clinical impression included metformin and an antipsychotic overdose.</p> <p>On 8/17/23 the resident also became severely hypotensive (low blood pressure), lost consciousness and became unresponsive. On 8/18/23 the resident had severe hypotension (shock), hypokalemia (low potassium critical for proper functioning of cells, particularly heart muscle cells), and lethargy. The resident was transferred to the ICU (Intensive Care Unit).</p> <p>On 3/28/24, Staff 1 (Administrator) provided the facility's Accident Incident Manual - Medication Error Check List which indicated Staff 6 failed to:</p> <ul style="list-style-type: none"> <li>-Ask the resident to state their name.</li> <li>-Use the picture identifier, the name plate on the resident's door or any other acceptable identifier prior to administering the medications to Resident 101.</li> </ul> <p>(continued on next page)</p>		

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F 0760  Level of Harm - Actual harm  Residents Affected - Few	<p>On 3/29/24 at 8:15 AM, Staff 6 (LPN) stated he gave Resident 101 ten medications prescribed for Resident 106 shortly after 7:00 PM. Staff 6 stated while giving Resident 101 she/he stated this was a lot of medications. Staff 6 stated he did not follow up on the remark. Staff 6 stated it was a lapse in his practice for not verifying the correct resident before administering the medications. Staff 6 stated he also went back and gave Resident 101 her/his prescribed medications after being aware of his initial medication error. The resident received mirtazapine (an antidepressant medication), Eliquis (a blood thinner medication), vitamin D and artificial tears eye drops. Medication documentation indicated the resident received those medications at 8:30 PM which was after the 7:00 PM medication error and she/he was also administered nitroglycerin (heart medication) at 10:39 PM. Staff 6 stated, I should have checked with someone before giving her/him additional medications on top of the incorrect medications. I just used my nursing judgement.</p> <p>On 4/1/24 at 1:40 PM, Staff 1 (Administrator) and Staff 2 (DNS) confirmed Staff 6 made a significant medication error which resulted in Resident 101 being hospitalized. Staff 1 acknowledged Staff 6 did not follow protocol for the safe administration of medications and failed to contact the physician prior to administering additional medications to Resident 101. Staff 1 also confirmed Staff 6 failed to provide appropriate documentation in the medical record for the other resident whose medications were administered to Resident 101.</p>		