STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385152	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Grove Post Acute	515 Grant Street Cottage Grove, OR 97424

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 - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25504 Based on interview and record review it was determined the facility failed to ensure resident pain medication was not misappropriated for 1 of 3 sampled residents (#3) reviewed for abuse. This placed residents at risk for increased pain. Findings include: Resident 3 was admitted [DATE] with diagnoses including a leg fracture. Review of a facility's policy Ordering and Receiving Controlled Medications dated 1/2023 revealed the facility must document and verify the quantity of controlled substances received. Review of a pharmacy medication receipt dated 9/26/24 revealed three cards of narcotic medication was delivered to the facility including medication for Resident 3. The receipt was initialed by Staff 3 (LPN). Review of the Facility Reported Incident Form (FRI) dated 9/26/24 revealed a medication card of narcotics (oxycodone 10 mg 14 tablets) for Resident 3 was missing. The form indicated the resident did not miss any doses of pain medication, the facility was searched and law enforcement was notified. Review of the Facility Reportable Incident (investigation) form dated 9/27/24 revealed on 9/26/24 between 10 PM and 10:30 PM the facility received narcotic medication for several residents including Resident 3 all in one package. The medications were received by Staff 4 (LPN) who did not check the contents of the package. At 2:45 AM Staff 3 notified the administrator Resident 3's pain medication card of 14 tablets of oxycodone was missing. The investigation also indicated the medications were not located in the building and the facility could not substantiate or unsubstantiated misappropriation at the time. In an interview on 10/15/24 at 7:30 AM Staff 4 said on 9/26/24 pharmacy delivered some narcotic medications around 10-10:30 PM. Staff 4 said the facility received three cards of narcotics and one card was for Resident 3. Staff 4 said she double checked the package to make sure all the medications were there and placed the package behind the nursing station visible to anyone. Staff 4 said Staff 3 was administering medications to residents that night and Staff 3 was on break when the medications arrived. Staff 4 said she did not have direct observation of the package of medications from the time they arrived to 2:45 AM. Staff 4 said she told Staff 3 pain medications were delivered around 2:45 AM, and said Staff 3 had informed her Resident 3's pain medications were missing. (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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(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 - Few	In an interview on 10/15/24 at 9:50 AM Staff 3 said on 9/26/24 the pharmacy delivered a package of narcotic medications while she was on break from 11:00 PM to 11:20 PM. Some time between 11:30 PM and 12 AM, Staff 3 noticed a package of medications on a computer at the nurse's station. Staff 3 said she checked the medications and found Resident 3's card of oxycodone was missing. Staff 3 said no one had told her the medications were delivered. In an interview on 10/16/24 9:00 AM Staff 1 acknowledged facility policy was not followed by staff regarding Resident 3's medication and the medication was misappropriated. On 9/27/24, the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined there was misappropriation of pain medications. The Plan of Correction included: 1. Staff educated on policy and procedures of pharmaceutical receipt, documentation and storage, 2. Auditing procedure and verification processes by DON and Administrator, and 3. Monthly review of receipt and storage of medications and audits to be performed daily for three weeks, weekly for three weeks and then monthly.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 25504 Based on interview and record review it was determined the facility failed to store narcotic pain medications in a safe manner. This placed residents at risk for misappropriation of medications. Findings include: Review of the facility's Controlled Medication Storage policy dated 1/2024 revealed narcotic pain medication must be maintained in separately locked permanently affixed compartments. Review of a pharmacy medication receipt dated 9/26/24 revealed three cards of narcotic medication was delivered to the facility and receipt was initialed by Staff 3 (LPN). Review of the Facility Reported Incident Form (FRI) dated 9/26/24 revealed a medication card of narcotics (oxycodone 10 mg 14 tablets) for Resident 3 was missing. The form indicated the resident did not miss any doses of pain medication, the facility was searched and law enforcement was notified. Review of the Facility Reportable Incident (investigation) form dated 9/27/24 revealed on 9/26/24 between 10 PM and 10:30 PM the facility received narcotic medication for several residents all in one package. The medications were received by Staff 4 (LPN) who did not check the contents of the package and placed the package behind the nursing station. At 2:45 AM Staff 3 notified the administrator Resident 3's pain medication card of 14 tablets of oxycodone was missing. In an interview on 10/15/24 at 7:30 AM Staff 4 said on 9/26/24 pharmacy delivered some narcotic medications around 10-10:30 PM. Staff 4 said the facility received three cards of narcotics. Staff 4 said she double checked the package to make sure all the medications were there and placed the package behind the nursing station visible to anyone. Staff 4 said she did not have direct observation of the package of medications from the time they arrived at 2:45 AM. In an interview on 10/15/24 at 9:50 AM Staff 3 said on 9/26/24 the pharmacy delivered a package of narcotic medications while she was on break from 11:00 PM to 11:20 PM. Some time between 11:30 PM and 12 AM Staff 3 noticed a package of medications sitting on a computer at the nurse's station. In an interview on 10/16/24 9:00 AM Staff 1 acknowledged facility policy was not followed by staff regarding safe storage of narcotic medications. On 9/27/24, the Past Noncompliance was corrected when the facility completed a root cause analysis of the incident and determined there was improper storage of narcotic pain medications. The Plan of Correction included: 1. Staff educated on policy and procedures of pharmaceutical receipt, documentation and storage, 2. Auditing procedure and verification processes by DON and Administrator, and 3. Monthly review of receipt and storage of medications and audits to be performed daily for three weeks, weekly for three weeks and then monthly.