

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Linda Vista Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 135 Maple Street Ashland, OR 97520	

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>22762</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from misappropriation of controlled (medications that are counted and stored in a locked area) narcotic and sedative medications for 2 of 2 sampled residents (#s 4 and 6) reviewed for drug diversion. This placed residents at risk for unmet medication care needs. Findings include:</p> <p>Correction of noncompliance related to misappropriation of resident medications was completed on 2/2/22 after the facility conducted an investigation including staff interviews, review of the incident by QAPI and training for staff who monitored and administered medications.</p> <p>On 1/28/22 the facility submitted a FRI to the State Agency related to Witness 1 (Agency Nurse) who was observed by other facility nursing staff to appear impaired. Staff 2 (DNS) and Staff 4 (Resident Care Manager - LPN) checked the controlled medications and discovered two bottles of Resident 6's methadone (used to treat opioid dependence) were missing from a locked container. Staff 2 and Staff 4 further discovered Resident 4's bottle of Ativan (sedative) liquid had a smaller quantity than was documented on the sign-out page. A facility nurse was assigned to replace Witness 1 and provide care for the residents on the unit. Local law enforcement was notified and when Witness 1 was arrested, she produced two bottles of methadone from her pocket and gave them to responding officers. Witness 1 was subsequently arrested for theft of the medications.</p> <p>Residents involved in the incident on 1/28/22 included:</p> <p>a. Resident 4 was admitted to the facility in 1/2022 with diagnoses including end- stage kidney disease. Resident 4 was prescribed Ativan on a PRN basis. Resident 4's Progress Notes and 1/2022 MAR revealed she/he did not experience symptoms of anxiety or request any doses of Ativan on 1/28/22.</p> <p>b. Resident 6 was admitted to the facility in 1/2022 with diagnoses including burn wounds and liver disease. Resident 6 was ordered methadone. Resident 6's 1/2022 MAR revealed she/he received scheduled methadone doses as ordered.</p> <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>On 4/18/24 at 1:10 PM Staff 5 (Resident Care Manager - LPN) stated she completed any tasks related to resident needs, checked for noon time insulin doses that were potentially missed and placed them on alert if needed. Staff 5 stated a new resident was admitted earlier in the day and Witness 1 did not complete the necessary paperwork. Staff 5 indicated she completed the new resident's admission process. Staff 5 stated there were no residents directly impacted by Witness 1's actions and residents were not aware of what occurred. Staff 5 revealed Witness 2 (Former Staff - CMA) was also present while Witness 1 was working and was concerned about her behavior. Staff 5 stated Witness 2 found Witness 1 passed out in a bathroom and immediately reported her concerns and observations to other staff and management.</p> <p>On 4/18/24 at 2:33 PM Staff 6 (LPN) stated Witness 1 was not acting right when she observed her working. Staff 6 revealed she and another nurse went to Staff 2 (DNS) and reported their concerns about Witness 1's behavior.</p> <p>On 4/18/24 at 2:43 PM Staff 2 acknowledged the misappropriation of resident medications by Witness 1. Staff 2 stated she and Witness 2 immediately checked the methadone locked box and discovered there were two bottles missing and another bottle was half empty. Staff 2 indicated a bottle of Ativan was also observed to be missing doses. Staff 2 stated resident records were reviewed and no residents missed any doses of their medications.</p> <p>On 4/18/24 at 3:08 PM Staff 3 (Resident Care Manager - LPN) stated she was on duty 1/28/22 and asked Witness 1 if she needed help. Staff 3 observed Witness 1 almost asleep at the computer keyboard and unable to enter her password. Staff 3 stated she saw Witness 1 was not moving and unable to do her job and knew there was something wrong. Staff 3 reported her observations to Staff 1.</p> <p>During an interview on 4/19/24 at 9:09 AM Staff 1 (Administrator) acknowledged the incident regarding Witness 1's misappropriation of resident medications. Staff 1 stated facility staff promptly reported concerns related to Witness 1 and immediate interventions were provided.</p>