STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39651 Based on interview and record review, the facility failed to ensure staff consistently followed and implemented abuse and neglect policies and procedures for reporting and investigation of an allegation of neglect for 1 of 3 residents (Resident 2) reviewed for abuse and neglect. This failure placed residents at risk for abuse and neglect. Findings Included . A review of the facility's abuse and neglect policy titled, Abuse Prohibition, dated 04/09/2021, showed that the facility will report all alleged violations to the State Agency and to all other agencies as required. The policy showed the facility will thoroughly investigate allegations of abuse and neglect and will be documented as required. The policy directed the facility staff to: 1. Report all allegations involving neglect within 24 hours if the event does not result in serious bodily injury. 2. Initiate the investigation within 24 hours of the allegation of abuse that focuses on whether abuse and neglect occurred and to what extent; clinical examinations for signs of injuries if indicated, causative factors, and interventions to prevent further injury. Resident 2 was a long term care resident of the facility. The resident's diagnoses list included Guillain-Barre syndrome (muscle weakness/paralysis), dementia (memory problem) and seizure disorder. A review of Resident 2's care plan, dated 10/22/2018 and revised on 06/28/2021, showed Resident 2 required total staff assistance with bed mobility, transfers, toileting and personal hygiene needs. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/09/2021 at 8:45 AM, a resident family member (FM1) stated she came and visited Resident 2 with another family member (FM2) in the facility on 07/23/2021 at around 4:30 PM. FM1 stated when they arrived, they found Resident 2 in bed in a very awful condition. FM1 stated that the resident was covered with her own feces throughout her body, some of which were already dried, the pillows and blankets were also covered with feces, had dirty and long fingernails, and appeared to be dehydrated. FM1 also stated that the resident's tube feeding (artificial tube in the abdomen area) was also leaking, and the resident's room had bugs coming from the open window with no screen. FM1 stated that she was appalled and horrified at Resident 2's condition, so she immediately notified a manager on duty, Staff D, Director of Admissions (DOA), of her concerns. FM1 further stated that what they saw was clear neglect of care and she had asked for an investigation into why Resident 2 was in such an awful condition. On 08/10/2021 at 10:15 AM, Staff D, DOA stated that she was aware of the concerns regarding Resident 2. Staff D stated that FM1 had reported to her on 07/23/2021 that Resident 2 was covered with feces, the tube feeding was leaking, and had fingernail debris. Staff D also stated there were other issues reported to her, including the resident's personal television being left at her old room. According to Staff D, she immediately reported these concerns to a nurse manager and maintenance staff, but she did not complete a grievance or concern report and no other follow-up was made. Staff D further stated that she did not think of the alleged incident as an allegation of neglect, so she did not report the incident to the state agency. On 08/10/2021 at 10:55 AM, Staff B, Director of Nursing, stated she could not recall when she was made aware of the alleged incident, but she also did not think of the incident as an allegation of neglect because the facility staff had addressed the concerns at the time of the incident was reported to Staff D, DOA. Staff B also stated that this alleged incident was not reported to the state agency and there was no investigation completed to rule out whether there was abuse or neglect of care. Reference: (WAC) 388-97-0640 (2)(a)(b)

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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 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. 39651 Based on interview and record review, the facility failed to report an allegation of neglect to the state agency as required for 1 of 3 residents (Resident 2) reviewed for abuse and neglect. This failure placed residents at risk for abuse and neglect. Findings included . Resident 2 was a long term care resident of the facility. The resident's diagnoses list included Guillain-Barre syndrome (muscle weakness/paralysis), dementia (memory problem) and seizure disorders. On 08/09/2021 at 8:45 AM, a resident family member (FM1) stated that she came and visited Resident 2 with another family member (FM2) in the facility on 07/23/2021 at around 4:30 PM. FM1 stated that when they arrived at the facility, they found Resident 2 in bed covered with her own feces, some of which was already dried, the pillows and blankets were also covered with feces, had dirty and long finger nails, and appeared to be dehydrated. FM1 stated that she immediately reported her concerns to Staff D, Director of Admissions (DOA). On 08/10/2021 at 10:15 AM, Staff D, DOA, stated that she was aware of the concerns regarding Resident 2. Staff D stated that FM1 had reported to her on 07/23/2021 that Resident 2 was covered with feces, the tube feeding was leaking, and had fingernail debris. However, Staff D stated that she did not think of the incident as an allegation of neglect, so she did not report the incident to the state agency as required. On 08/10/2021 at 10:55 AM, Staff B, Director of Nursing, stated the alleged incident regarding Resident 2 was not reported to the state agency as required. There was no documented evidence that the facility had reported the allegation of neglect regarding Resident 2 to the state agency as required. Reference: (WAC) 388-97-0640 (5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 39651 Based on interview and record review, the facility failed to investigate an allegation of neglect for 1 of 3 residents (Resident 2). This failed practice placed residents at risk for harm and left unanswered questions whether the incident was potentially related to abuse and/or neglect. Findings included . Resident 2 was a long-term care resident of the facility. The resident's diagnoses list included Guillain-Barre syndrome (muscle weakness/paralysis), dementia (memory problem) and seizure disorder. A review of Resident 2's care plan, dated 10/22/2018 and revised on 06/28/2021, showed Resident 2 required total staff assistance with bed mobility, transfers, toileting and personal hygiene needs. On 08/09/2021 at 8:45 AM, a resident family member (FM1) stated she came and visited Resident 2 with another family member (FM2) in the facility on 07/23/2021 at around 4:30 PM. FM1 stated when they arrived, they found Resident 2 in bed in a very awful condition. FM1 stated that the resident was covered with her own feces throughout her body, some of which were already dried, the pillows and blankets were also covered with feces, had dirty and long fingernails, and appeared to be dehydrated. FM1 also stated that the resident's tube feeding (artificial tube in the abdomen area) was also leaking, and the resident's room had bugs coming from the open window with no screen. FM1 stated that she was appalled and horrified at Resident 2's condition, so she immediately notified a manager on duty, Staff D, Director of Admissions (DOA), of her concerns. FM1 further stated that what they saw was clear neglect of care and she had asked for an investigation into why Resident 2 was in such a very awful condition. On 08/10/2021 at 10:15 AM, Staff D, DOA, stated that she was aware of the concerns regarding Resident 2. Staff D stated that FM1 reported to her on 07/23/2021 that Resident 2 was covered with feces, the tube feeding was leaking, and had fingernail debris. However, Staff D stated that she did not think of the incident as an allegation of neglect. On 08/10/2021 at 10:55 AM, Staff B, Director of Nursing, stated that there was no investigation completed related to the allegation of neglect regarding Resident 2 to rule out whether there was abuse or neglect of care. There was no documented evidence that the facility had investigated the allegation of neglect regarding Resident 2 to as required. Reference: (WAC) 388-97-0640 (6)(a-c)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on observation, interview and record review, the facility failed to provide adequate pain management to meet the needs of each resident for 1 of 3 residents (Resident 1) reviewed for pain. This failure caused harm to Resident 1 who experienced severe pain and discomfort. Findings included . Resident 1 was admitted to the facility on [DATE] for rehabilitation therapy. The resident's diagnoses list included a complicated major abdominal surgery. The resident was admitted to the facility with an order for Hydromorphone (a narcotic pain medication) 2 milligram (mg) to 6mg every 3 hours as needed for moderate to severe pain. On 07/23/2021 at 11:30 AM, Staff B, Director of Nursing (DNS) stated that Resident 1 was admitted to the facility around 3:00 PM on 07/20/2021. Staff B stated that the resident had reported to facility staff that she had not received her Hydromorphone for at least 12 hours after admission, which caused severe pain and poor pain management for Resident 1. Staff B stated that the facility had initiated an investigation as to what could have happened and why the resident did not receive her narcotic pain medication as ordered. A review of the resident's clinical records, including Medication Administration Records (MAR), Nursing Progress notes and Narcotic Pain Medication Log from 07/20/2021 to 07/23/2021, showed Resident 1 did not receive any Hydromorphone until 07/21/2021 at 4:00 AM. The nursing progress note, dated 07/21/2021 at 5:09 AM, showed the resident requested Hydromorphone on 07/20/2021 at 5:00 PM (approximately 2 hours after admission). The progress notes also showed Staff C, Licensed Practical Nurse (LPN) started communication with the (offsite) pharmacy regarding the need for the resident's narcotic medication. Staff C's initial communication to the pharmacy requested an authorization number/code to access and remove a dose(s) of Hydromorphone medication for Resident 1 out of the facility's emergency kit (e-kit/Pyxis machine) to tide her over until her prescription arrived from the pharmacy. However, Staff C did not hear back/receive any communication from the pharmacy until 07/21/2021 at 4:00 AM when the medication [resident's Hydromorphone] was delivered. On 07/23/2021 at 11:50 AM, Resident 1 stated that she was in severe, excruciating, agonizing pain on 07/20/2021 from around 4:00 PM until the following morning (07/21/2021) at 4:00 AM. Resident 1 also stated that her pain was so severe that she wanted to call 911 to get her back to the hospital because she can't take it anymore being in so much pain. According to the resident, she could not understand why the facility did not give her the pain medication. Resident 1 stated that the hospital made it clear to her that due to her recent surgery and type of procedure that she undergone, it was very important for her to take the medication at least every 3 hours until her pain got under control. The resident further stated that she was afraid that she would develop withdrawal symptoms from narcotics (she received while at the hospital) because she then did not receive any of the pain medication for at least 12 hours at the facility. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The resident became tearful and stated that she was upset with what happened and certainly would not like to experience the same situation. Observation showed the resident's abdomen had a large abdominal wound dressing and a drainage bag from a colostomy (an artificial opening in the abdomen). The resident stated, These are the reasons why I am in severe pain (pointing at the abdominal wounds area), and that her pain could not be relieved by simply taking Tylenol (an over-the-counter pain medication/fever reducer). The resident stated that she finally fell asleep while waiting for the pain medication because she was extremely exhausted from being in so much pain. Both the MAR and the Narcotic Pain Medication log showed the resident complained of severe pain and received the highest dose ordered, Hydromorphone (6mg), thirteen times since the medication became available on 07/21/2021. On 07/23/2021 at 12:20 PM, Staff D, Registered Nurse (RN) stated she was the day shift nurse who came on duty soon after Resident 1 had received her first dose of Hydromorphone at 4:00 AM. Staff D stated that the resident reported severe agonizing pain during her shift and requested Hydromorphone almost every 3 hours to ease and manage her pain to the abdomen and lower back area. According to Staff D, Resident 1 reported she was not feeling good and was hurting so bad the entire night without pain medication. On 07/23/2021 at 3:00 PM, Staff C, Licensed Practical Nurse (LPN) stated that Resident 1 was admitted to the facility on [DATE] at 3:00 PM. Staff C stated Resident 1 arrived to the facility with a valid prescription for the Hydromorphone which was immediately sent to the pharmacy to be processed. Staff C also stated that he spoke to a pharmacy staff who acknowledged the receipt of the prescription for Hydromorphone, but the pharmacy staff refused to provide him with an authorization number to remove the medication from the facility e-kit and told him that they would fax him the authorization number. According to Staff C, Resident 1 complained of severe pain and had requested Hydromorphone at around 5:00 PM on 07/20/2021. Staff C stated that he attempted to call the pharmacy at least 5 times and left messages, but he did not hear back from the pharmacy until the medication arrived at the facility on 07/21/2021 at 4:00 AM. Staff C further stated that he attempted to offer the resident Tylenol while waiting for the Hydromorphone, but the resident had refused. Staff C also stated that he did not notify the doctor or the Director of Nursing/facility administration about the delay in access issue with Resident 1's narcotic medication. Staff C stated that he should have called the doctor and the Director of Nursing, as both could have helped him with the situation in getting the authorization number and ensuring timely administration of the medication. On 08/02/2021 at 11:00 AM, Staff B, DNS, stated the pharmacy had reviewed and revised its process in providing authorization number to the facility. Staff B stated that the root cause of this incident was due to the pharmacy's procedure of not providing authorization code timely to access the facility's emergency kit. Staff B also stated that Staff C LPN should have called her when he had trouble contacting the pharmacy in obtaining authorization, so she could have intervened and call the pharmacy herself to assist in the process. Staff B further stated that no resident should experience what Resident 1 had experienced, to be in so much pain and not able to receive the medication timely as ordered after a major surgery. Staff B added that the incident was clearly avoidable and the process in acquiring an authorization number from the pharmacy should have been better than this to meet the needs of the residents. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Reference WAC: 388-97-1060 (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate and timely acquiring, receiving, dispensing, and administering of all drugs, to meet the needs of each resident for 1 of 3 residents (Resident 1) reviewed for pharmacy services. Failure to ensure timely administration of a narcotic pain medication caused harm to Resident 1 who experienced severe pain and discomfort. Findings included . Resident 1 was admitted to the facility on [DATE] for rehabilitation therapy. The resident's diagnoses list included a complicated major abdominal surgery. The resident was admitted to the facility with an order for Hydromorphone (a narcotic pain medication) 2 milligram (mg) to 6mg every 3 hours as needed for moderate to severe pain. A review of the resident's clinical records, including Medication Administration Records (MAR), Nursing Progress notes and Narcotic Pain Medication Log from 07/20/2021 to 07/23/2021, showed Resident 1 did not receive any Hydromorphone until 07/21/2021 at 4:00 AM. The nursing progress note, dated 07/21/2021 at 5:09 AM, showed the resident requested Hydromorphone on 07/20/2021 at 5 PM (approximately 2 hours after admission). The progress note also showed Staff C, Licensed Practical Nurse (LPN) started communication with the (offsite) pharmacy regarding the need for the resident's narcotic medication. Staff C's initial communication to the pharmacy requested an authorization number/code to access and remove a dose(s) of Hydromorphone medication for Resident 1 out of the facility's emergency kit (e-kit/Pyxis machine) to tide her over until her prescription arrived from the pharmacy. However, Staff C did not hear back/receive any communication from the pharmacy until 07/21/2021 at 4:00 AM when the medication [resident's Hydromorphone] was delivered. On 07/23/2021 at 11:50 AM, Resident 1 stated that she was in severe, excruciating, agonizing pain on 07/20/2021 from around 4:00 PM until the following morning (07/21/2021) at 4:00 AM. Resident 1 also stated that her pain was so severe that she wanted to call 911 to get her back to the hospital because she can't take it anymore being in so much pain. According to the resident, she could not understand why the facility did not give her the pain medication. Resident 1 stated that the hospital made it clear to her that due to her recent surgery and type of procedure that she undergone, it was very important for her to take the medication at least every 3 hours until her pain got under control. The resident further stated that she was afraid that she would develop withdrawal symptoms from narcotics (she received while at the hospital) because she then did not receive any of the pain medication for at least 12 hours at the facility. Both the MAR and the Narcotic Pain Medication log showed the resident complained of severe pain and received the highest dose ordered, Hydromorphone (6mg), thirteen times since the medication became available on 07/21/2021. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	On 07/23/2021 at 3:00 PM, Staff C, Licensed Practical Nurse (LPN) stated that Resident 1 was admitted to the facility on [DATE] at 3:00 PM. Staff C stated Resident 1 arrived to the facility with a valid prescription for the Hydromorphone which was immediately sent to the pharmacy to be processed. Staff C also stated that he spoke to a pharmacy staff who acknowledged the receipt of the prescription for Hydromorphone, but the pharmacy staff refused to provide him with an authorization number to remove the medication from the facility e-kit and told him that they will fax him with the authorization number. According to Staff C, Resident 1 complained of severe pain and had requested Hydromorphone at around 5:00 PM on 07/20/2021. Staff C stated that he attempted to call the pharmacy at least 5 times and left messages, but he did not hear back from the pharmacy until the medication arrived at the facility on 07/21/2021 at 4:00 AM. Staff C further stated that he attempted to offer the resident Tylenol while waiting for the Hydromorphone, but the resident had refused. On 08/02/2021 at 11:00 AM, Staff B, DNS, stated the pharmacy had reviewed and revised its process in providing authorization number to the facility. Staff B stated that the root cause of this incident was due to the pharmacy's procedure of not providing authorization code timely to access the facility's emergency kit. Staff B also stated that Staff C LPN should have called her when he had trouble contacting the pharmacy in obtaining authorization, so she could have intervened and call the pharmacy herself to assist in the process. Staff B further stated that no resident should experience what Resident 1 had experienced, to be in so much pain and not able to recieve the medication timely as ordered after a major surgery. Staff B added that the incident was clearly avoidable and the process in acquiring an authorization number from the pharmacy should have been better than this to meet the needs of the residents. Reference WAC: 388-97-1300(1)(a)(b)(i)(ii)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39651 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 8 of 19 residents (Residents 2, 3, 4, 5, 6, 7, 8, and 9) reviewed for medication errors. This failure placed the residents at risk for harm and related complications. Findings included . A review of the facility policy titled, Medication Errors, dated [DATE] and revised on [DATE], defined a medication error as a discrepancy between what the physician orders and what medication(s) the resident receives or did not receive (omission). Medication errors can include administration of the prescribed medication at the wrong time. RESIDENT 2 Resident 2 was a long-term care resident of the facility. The resident's diagnoses list included Guillain-Barre Syndrome (muscle weakness/paralysis), dementia and seizure disorder. A review of the resident's MAR for [DATE] showed the resident did not received the following medications as scheduled on the morning of [DATE]: A. Levetiracetam - an anti-seizure/anti-epilepsy medication. B. Baclofen - a muscle relaxant used by Resident 2 for Guillain-Barre Syndrome. C. Lamictal - an anti-seizure/anti-epilepsy medication. D. Ativan - an anti-anxiety medication E. Ferrous Sulfate - an iron supplement F. Ascorbic acid (Vitamin C) - a supplement G. Cholecalciferol (Vitamin D) - a supplement H. Probiotic capsules - a supplement I. Clotrimazole cream - an anti-fungal cream J. Hydrocortisone lotion - an anti-itch cream Also on [DATE] (morning shift), the facility staff did not administer the following as per physician orders: Jevity tube feeding formula (administered via tube to the stomach) 650 milliliters (mL) and water flushes via tube feeding (600 mL). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's clinical records showed that on [DATE], the resident had a decline in condition. The resident was found to have a fever of 100 degrees Fahrenheit and the resident had foam surrounding her mouth, skin was cold and clammy on arms and legs, face red and sweating. The resident unresponsive and had vital signs recorded as follows: Blood Pressure of ,d+[DATE] (normal range is ,d+[DATE]), Pulse Rate of 158 (normal range is ,d+[DATE]) and Respiration Rate of 40 (normal range is ,d+[DATE]). The resident was transported to the local hospital for further evaluation and treatment. A review of the facility's medication error incident investigation, dated [DATE], showed the resident did not received all the medications [as listed on the MAR for morning [DATE]]. The investigation indicated the nurse responsible for the medication error did not follow the facility's medication errors policy in that the doctor and the resident's responsible party were not notified of the medications error (omission), and there was no monitoring for potential adverse reactions and/or side effects related to the missed medications. On [DATE] at 8:45 AM, a resident family member (FM1) stated the resident died at the hospital on [DATE]. FM1 stated that the resident was neglected at the facility and did not get adequate care and services such as making sure that the tube feeding tube was properly in place when administering medications and food. According to FM1, Resident 2 was severely dehydrated and almost dead when she arrived at the hospital. A review of the hospital records dated [DATE] showed the resident was admitted to the hospital on [DATE] and died the following day on [DATE]. RESIDENT 3 A review of Resident 3's [DATE] MAR showed the resident did not receive the following medications as scheduled on the morning of [DATE]: A. Gabapentin - an anti-seizure/anti-convulsant medication that can be use for nerve pain. B. Bactrim DS (Double Strength) - an anti-infective/antibiotic medication. C. Clindamycin - an anti-infective/antibiotic medication. D. Potassium Chloride Extended-Release tablets - a potassium replacement supplement E. Nystatin Powder - an anti-fungal powder F. Clotrimazole cream - an anti-fungal cream G. Voltaren Gel - a medicated cream for pain H. Bactroban ointment - an anti-infective/antibiotic ointment RESIDENT 4 (continued on next page)

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	505042	A. Building B. Wing	08/17/2021

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Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 4's [DATE] MAR showed the resident did not receive the following medications as scheduled on the morning of [DATE]: A. Levetiracetam - an anti-seizure/anti-epilepsy medication. B. Baclofen - a muscle relaxant. C. Gabapentin - an anti-seizure/anti-convulsant medication that can be use for nerve pain. D. Ipratropium-Albuterol solution - a breathing treatment Additionally on [DATE], facility staff did not administer the following as per physician orders: Glucerna supplement - a high caloric drink, or check Resident 4's blood sugar (related to diabetes). RESIDENT 5 A review of Resident 5's [DATE] MAR showed the resident did not receive the following medications as scheduled on the morning of [DATE]: A. Amlodipine tablet - an anti-hypertensive medication B. Sertraline tablet - an anti-depressant medication C. Lactulose solution - a medication used to reduce the amount of ammonia used by Resident 5 due to Liver Cirrhosis (liver damage). D. Sodium Bicarbonate tablet - an alkalinizing (anti-acidic) formula/supplement E. Prenatal Vitamins - a supplement F. Vitamin B1 - a vitamin supplement G. Ascorbic acid (Vitamin C) - a vitamin supplement H. Ferrous sulfate - an iron supplement RESIDENT 6 A review of Resident 6's [DATE] MAR showed the resident did not receive the following medications as scheduled on the morning of [DATE]: A. Carbidopa-Levodopa - an anti-Parkinson's medication B. Baclofen - a muscle relaxant C. Hydralazine - an anti-hypertensive medication D. Sulfamethoxazole-Trimethoprim - an anti-infective/antibiotic medication (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 7 A review of Resident 8's [DATE] MAR showed the resident did not receive the following medications as scheduled on the morning of [DATE]: A. Tramadol tablet - a narcotic pain medication B. Digoxin tablet - a heart medication for heart failure C. Cefdinir capsule - anti-infective/antibiotic medication D. Diclofenac Sodium Gel - a topical pain medication E. A specific wound care order for a stage 4 pressure ulcer/injury (bedsore that includes damage to the deepest layer of skin and structures including the bone and muscle.) RESIDENT 8 A review of Resident 7's [DATE] MAR showed the resident did not receive his Metamucil Fiber Packet (a fiber supplement for constipation) as scheduled on the morning of [DATE]. RESIDENT 9 A review of Resident 9's [DATE] MAR showed the resident did not receive a treatment medication, Callus Control Cream (a medicated cream), as scheduled on the morning of [DATE]. On [DATE] at 10:35 AM, Staff E, Registered Nurse (RN) stated that she had covered [the medication cart] for the originally scheduled day shift nurse on [DATE]. Staff E stated that Residents 2, 3, 4, 5, 6, 7, 8 and 9 did not receive their morning medications, as ordered by the physician, on [DATE]. Staff E stated that the residents, any legal representative(s), and the physician were not notified of the medication errors. Staff E also stated that there was no monitoring and/or follow-up related to the medication errors to ensure residents did not suffer any adverse side effects and/or reactions related to the medication omissions. On [DATE] at 11:00 AM, Staff B, DNS, stated that there was an on-going investigation related to the medication errors that occurred on [DATE]. Then on [DATE] at 11:00 AM, Staff B, DNS, confirmed that the medication errors (omission) occurred for Residents 2, 3, 4, 5, 6, 7, 8 and 9. Staff B also stated that Staff E did not monitor those residents afterwards for any potential adverse side effects, and did not notify the physician and/or the residents and responsible party(s) regarding the medication error(s) that occurred on [DATE]. Reference: WAC [DATE] (1)(3)(k)(iii)