STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. Building B. Wing	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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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 - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to implement its Abuse and Neglect Policy and Procedure for 2 of 4 allegations of abuse or neglect reviewed, to include identification of abuse and neglect, responding to and reporting the allegations to the State Agency (SA), timely investigating, and protecting 1 (Resident 1) of 3 residents reviewed for abuse. This failure placed the resident and other residents at risk for continued verbal and psychological abuse, neglect, and a diminished quality of life. Findings included . An undated facility policy titled Prevention and Reporting Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property showed that the facility prohibited abuse, neglect, and exploitation of residents and misappropriation of resident property by anyone, including staff, resident representative/family, and friends. This policy showed the facility would report to the SA as soon as possible, but no later than two hours, if an allegation involved abuse or resulted in serious bodily injury, or no later than 24 hours if it did not involve abuse or resulted in bodily injury. This policy defined abuse and the different types of abuses and neglect and who was a mandated reporter. The policy showed procedures which included screening and training of staff, prevention of abuse, identification of abuse, investigation of abuse and neglect allegations, protecting the resident, responding to the allegation and reporting it to the SA. Significant Medication Error Review of Appendix C, Medication Error Decision Tree, found in the October 2015 Abuse and Neglect Prohibition Guidelines (used by staff to determine abuse or neglect), showed that when a medication error placed the resident at significant risk for harm and may be abuse or neglect, the facility must report it to the SA Hotline and log the event. Review of 03/09/2022 progress notes showed Resident 1 admitted to the facility on [DATE] with medically complex diagnoses, to include seizures. Review of the March 2022 Medication Administration Records (MAR) showed an order dated 03/09/2022 to administer 450 milligrams (mg) of Lamotrigine (a seizure medication) at 8:00 AM and 300 mg at 8:00 PM. (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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the March 2022 MAR showed staff failed to administer the evening dose of Lamotrigine on 03/09/2022, missed both doses on 03/10/2022, and missed the morning dose of 03/11/2022, for a total of 4 missed doses. A 03/11/2022 6:13 PM progress note showed Resident 1 became unresponsive, had a small seizure, and was transferred to the hospital. On 03/18/2022, a Collateral Contact stated, Missing doses of Lamictal (Lamotrigine)? That's a big deal. Yes, it's a bit concerning, indeed. The Collateral Contact stated that because of Lamotrigine's short half-life (the time it takes for the amount of a drug's active substance in the body to reduce by half), missing doses placed Resident 1 at significant risk for harm. Review of the March 2022 Mandated Reporting Log showed no documentation the facility notified the SA Hotline as required for a significant medication error until 03/17/2022, six days after the facility became aware a significant medication error occurred and the day the Investigator informed the facility of the issue. Similarly, review of a 03/17/2022 facility Investigative Report (IR) showed that the facility started the investigation on 03/17/2022. The IR showed no interviews with the nurses who were aware of and did not report the missed medication doses between 03/09/2022 and 03/11/2022. Interview statements are key in identifying elements that lead up to the incident. The IR showed that Resident 1 did not receive the Lamotrigine for 3 days, and that the Staff A (Administrator) and Staff B (Director of Nursing) were aware of the significant medication error as of 03/11/2022. The IR concluded on 03/17/2022 that the medication error happened because the facility never received notification from the pharmacy that clarification was needed prior to dispensing the Lamotrigine. The IR showed the facility reviewed pharmacy faxes and found no alerts to the facility asking for clarification. Contrary to the IR conclusion, review of Resident 1's medical record showed that the facility received pharmacy faxes on 03/10/2022 and 03/11/2022, and were aware the pharmacy could not dispense the unusually high dose of Lamotrigine until the physician called the pharmacy. On 03/18/2022 at 2:41 PM, a pharmacy collateral contact stated that the pharmacy sent faxes to the facility on [DATE], 03/10/2022 and 03/11/2022. On 03/17/2021 at 4:35 PM, Staff B stated that, The problem was that the nurses did not report it [the missed Lamotrigine doses]. Staff B stated that she thought she had asked staff to create an incident report for the significant medication error and that, It's not there. Staff B acknowledged that the medication error should have been, but was not, logged and stated that they would start an investigation right now. Staff to Resident Abuse Review of October 2015 Abuse & Neglect Prohibition Guidelines Appendix D, Reporting Guidelines for Nursing Homes, showed that for allegations of abuse, neglect, mistreatment, sexual or physical abuse/assault, the facility is to notify the SA Hotline and log the event within 5 days. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 3/11/2022 11:51 AM progress note showed that Resident 1 was very upset and aggressive with staff, yelling and cursing at staff regarding the missing [Lamotrigine] doses. This note showed that Staff C, Resident Care Manager, informed the resident sternly to ensure point was made that there are 3 options, Resident can go to hospital and be medicated in the ER [emergency room], resident can go AMA [Against Medical Advice] if unhappy with care in the facility, or resident could wait until pharmacy delivered the medication. A subsequent note of 3/11/2022 and written by Staff B showed that Resident 1, was concerned that [they] hadn't received [their Lamotrigine] as ordered. Staff B wrote that Staff C raised his voice to get Resident 1's attention and told Resident 1 that if the resident was really concerned the facility could send the resident home and arrange home health for them, or send them back to the hospital. The above progress notes were shared with Staff A, Administrator, on 03/17/2022 at 4:35. Staff A stated, None of that's ok. That is concerning. Review of the March 2022 Mandated Reporting log showed the facility logged the event and notified the SA Hotline on 03/17/2022, six days after the incident and the day the Investigator informed the facility of the issue. Review of the IR showed no documentation the facility interviewed caregivers in the immediate area or from other shifts to rule out other potential staff to resident abuse incidents. Review of the IR showed no documentation the facility put measures in place to protect other residents from possible staff to resident abuse or mistreatment from 03/11/2022 to 03/17/2022, or until the investigation ruled out abuse or neglect occurred. The above findings were shared with Staff A and B on 03/21/2022 at 1:56 PM. Staff A acknowledged the facility failed to implement its Abuse and Neglect policy. On 03/18/2022 at 12:07 PM, Resident 1 stated, It was a horrible experience. I didn't care when I left if I didn't even have pain medications. I walked out. It wasn't worth my life. Refer to F684 and F760 Reference WAC 388-97-0640(2).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to develop baseline care plans for 3 (Residents 1, 2 and 3) of 3 newly admitted residents reviewed for seizure management. Failure to develop baseline care plans placed the residents at risk for unmet care needs and adverse consequences associated with seizures. Findings included . An undated facility policy titled, Baseline Care Plan, showed the facility would develop a baseline care plan (CP) within 48 hours of a resident's admission. The baseline CP directed the staff with minimum healthcare information necessary to properly care for the resident. Resident 1 Review of a 03/14/2022 Minimum Data Set (MDS, an assessment tool) showed Resident 1 admitted to the facility on [DATE] with medically complex diagnoses, to include seizure disorder or epilepsy. A 03/03/2022 hospital History and Physical (H&P) note showed Resident 1 last had a seizure on 12/27/2021, and a history of a Vagal Nerve Stimulator (VNS, an implantable device that prevents or decreases seizure episodes). Review of the medical record showed no documentation the facility developed a baseline CP and related interventions for seizure management, to include the role of the VNS, side effects associated with VNS use, implant information like battery expiration date or type of VNS, or the role of therapy magnets for side effect management or first aid use. Resident 2 Review of the 03/22/2022 Admission MDS showed Resident 2 admitted to the facility on [DATE]. This MDS was In Progress. Review of a 03/14/2022 hospital H&P showed Resident 2 had a seizure diagnosis that was stable on maintenance medications. Review of the medical record showed no documentation the facility developed a baseline CP and related interventions for seizure management. Review of the Kardex (a tool used to provide pertinent care information to front line staff) showed no interventions to manage seizures or that Resident 2 even had a diagnosis of seizures. Resident 3 Review of the 03/08/2022 Admission MDS showed Resident 3 admitted to the facility on [DATE] and had no seizure disorder or epilepsy. Review of a 02/28/2022 hospital H&P showed Resident 2 had a past history of convulsions - One occurrence. Review of the March 2022 Medication Administration Record showed staff administered to Resident 3 Levetiracetam (medication) every 12 hours for Seizures. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed no documentation the facility developed a baseline CP and related interventions for seizure management. The above findings were shared with Staff D, Licensed Practical Nurse/Unit Manager on 03/21/2022 at 12:35 PM. Staff D stated that the Unit Managers completed the baseline CPs of new admissions to the facility. Staff D acknowledged the baseline CPs lacked interventions that provided staff the necessary healthcare information to properly care for residents with a seizure disorder. Refer to F684 Reference WAC 388-97-1020 (3).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure the care plans for 5 (Residents 4, 5, 6, 7 and 8) of 5 residents reviewed for seizures were reviewed and revised to accurately reflect interventions for seizure management. This failure placed the residents at risk for unmet care needs and adverse consequences related to seizures. Findings included . An undated facility policy titled, Care Plans, showed that the Care Plan (CP) provided information to the staff on how the causes and risks associated with issues and/or conditions could be addressed, in order to provide for the resident's highest practicable level of well-being. Resident 4 Review of a 03/09/2022 Significant Change Minimum Data Set (MDS, an assessment tool) showed Resident 4 admitted to the facility on [DATE]. This MDS showed Resident 4 had a seizure disorder or epilepsy diagnosis. Review of March 2022 Medication Administration Records (MAR) showed staff administered Divalproex Sodium Tablet twice a day for Seizure D/O [disorder]. Review of the medical record showed no documentation the facility developed a CP and related interventions for seizure management. Resident 5 Review of a 01/28/2022 Quarterly MDS showed Resident 5 admitted to the facility on [DATE]. This MDS showed Resident 5 had a seizure disorder or epilepsy diagnosis. Review of the March 2022 MAR showed staff administered Keppra Tablet to Resident 5 two times a day for Seizure D/O. Review of the medical record showed no documentation the facility developed a CP and related interventions for seizure management. Resident 6 Review of a 02/17/2022 Quarterly MDS showed Resident 6 admitted to the facility on [DATE]. This MDS showed Resident 6 had no seizure disorder or epilepsy. Review of a 12/08/2021 H&P showed no documentation Resident 6 had a diagnosis of a seizure disorder or epilepsy. Review of the March 2022 MAR showed staff gave Resident 6, Divalproex Sodium Tablet by mouth three times a day for a personal history of seizure. Review of the medical record showed no documentation the facility developed a care plan and related interventions for seizure management. On 03/21/2022 at 1:56 PM, Staff B, Director of Nursing, stated that a CP was not developed as the staff was unaware of Resident 6's personal history of seizure diagnosis. Resident 7 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 02/06/2022 Quarterly MDS showed Resident 7 admitted to the facility on [DATE]. This MDS showed Resident 7 had a seizure disorder or epilepsy diagnosis. Review of March 2022 MAR showed staff administered Depakote Tablet twice a day related to EPILEPTIC SEIZURES. Review of the medical record showed no documentation the facility developed a CP and related interventions for seizure management. Resident 8 Review of a 02/18/2022 Quarterly MDS showed Resident 8 admitted to the facility on [DATE]. This MDS showed Resident 8 had a seizure disorder or epilepsy diagnosis. Review of March 2022 MAR showed staff administered Zonisamide Capsule two times a day and Levetiracetam Tablet in the morning for Seizure D/O. Review of the medical record showed no documentation the facility developed a CP and related interventions for seizure management. On 03/18/2022 at 12:00 PM, Staff E, Certified Nursing Assistant (CNA), stated that they were assigned to all of the residents in the facility as a Float. Staff E stated that they obtained information about the residents from the nurses or from the Kardex (a record used by the aides and derived from the CP). Staff E was asked if they knew any of their residents had a seizure disorder and stated, I've never had a patient like that. On 03/18/2022 at 12:04 PM, Staff F, CNA, stated that they obtained information about the residents they cared for by getting used to the residents and allowing the residents the time to tell Staff F about themselves. Staff F was asked if they knew any of their residents had a seizure disorder and stated, When you get used to them, you can see the seizure, and you know something is wrong. On 03/18/2022 at 1:01 PM, Staff G, CNA, stated that they obtained information about the residents they cared for by, If they are coherent, I ask the residents, or the nurses. I check the Kardex. Some Kardex are not updated. Staff G stated that they typically were assigned to Rooms 33 to 44. This room assignment had a resident with a seizure disorder, Resident 8. Staff G stated, I work with [Resident 8] every day. I didn't know that. On 03/18/2022 at 1:56 PM, the above findings were shared with Staff B. Staff B acknowledged the lack of care planning for the residents with a seizure disorder. Staff B stated, We really missed it, and that the CPs should have something, somewhere about seizure management. Reference WAC 388-97-1020(1), (2)(a)(b).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to identify the presence of, put interventions in place for management of, and provide accurate treatment with the Vagal Nerve Stimulator (VNS, an implantable device that prevents or decreases seizure episodes) for 1 (Resident 1) of 8 residents reviewed for seizures. This failure caused Resident 1 to experience an adverse event, consequences associated with seizures, and subsequent hospitalization . Findings included . Review of the April 2020 VNS Therapy - Patient's Guide for Epilepsy showed that VNS therapy involves a small electrical device, like a pacemaker, which is implanted under the skin of a person's chest. It is designed specifically for people still living with seizures despite trying multiple medications. It is used as an add-on treatment for certain types of uncontrolled epilepsy (seizure disorder). VNS therapy helps reduce and makes seizures less severe. A person with a VNS implant is given a PATIENT INFORMATION CARD which shows the name of the person, the implantation date, generator and lead information, the physician and their contact number, and the model/serial numbers of the implant. The VNS implant has a battery inside that usually lasts a number of years. When the battery wears down, the generator will need to be replaced during a new procedure. The VNS implant can be set at different modes in an effort to prevent, stop, or shorten seizure episodes. The VNS implant also has different types of programming which allows customization based on the person's lifestyle preferences or side effect management. VNS therapy can give an extra stimulation at the onset of and during a seizure with the use of a small magnet. Each person who has a VNS implant is given a set of magnets. The VNS therapy magnet serves two functions, provide an extra dose of therapy on demand or temporarily suspend therapy to manage side effects during activities such as singing, public speaking or exercising. When a seizure happens, the person feeling the seizure or someone who sees it, can swipe the magnet over the VNS implant for less than two seconds. Each time the magnet is swiped this way, an extra burst of stimulation is given. This may help stop the seizure, make it shorter, less intense, or improve the recovery period following the seizure. VNS implant carriers are taught to teach others how to use the magnet and make it a routine part of their seizure first aid plans. When the magnet is held directly over the generator, the switch inside the generator is closed and stimulation will not be delivered. When the magnet is removed, the switch opens and the device is able to deliver stimulation. VNS implant carriers must always carry the magnet with them, available for use as soon as a seizure occurs or to temporarily suspend therapy for side effect management. Two magnets are provided to VNS implant carriers, along with a wristband and a belt clip. When worn with the wristband, the magnet should be on the inside of the wrist. VNS therapy magnets must be kept at least 10 inches away from credit cards, televisions, computers, microwave ovens, or other magnets. If dropped, it can break if it falls on a hard surface. The magnet can be used more than once during a seizure. The VNS therapy magnet is the only magnet that should be used with the VNS therapy system. Physicians must be contacted to get additional magnets. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The most common side effects seen with stimulation of the VNS implant include hoarseness or change in speech pattern, cough, tightness or pain in the throat or neck area, difficulty swallowing, headache, and difficulty breathing. Other adverse events reported include ataxia (loss of the ability to coordinate muscular movement), indigestion, impaired sense of touch, insomnia, pain, prickling of the skin, and vomiting. Therapy may also cause new onset sleep apnea (a sleep disorder in which breathing repeatedly stops and starts) in patients who have not previously been diagnosed with this disorder. A malfunction of the VNS therapy system could cause painful or direct current stimulation, which could result in nerve damage. The doctor must be notified if the person experiences troublesome or painful side effects from VNS therapy for an extended period of time. Patients should use the magnet to stop stimulation if they suspect a malfunction, and contact their physician immediately for further evaluation. On 03/18/2022 at 12:07 PM, Resident 1 stated that the VNS was placed right underneath the collar bone on the left side. Resident 1 stated that when they admitted to the facility, no one did a skin assessment and, I asked for the charge nurse or any nurse so I could teach them how to use the magnet in case I had a seizure. Never once did they come in or get the nurse to come in to learn. I told them immediately. I lifted up my shirt, and told them what [the VNS] was. I asked them if they can get the other nurses to show them. They wouldn't even do that. On 03/18/2022 at 11:31 AM, a Neurology Collateral Contact stated that, Resident 1's VNS was active after the neck surgery. The Collateral Contact stated that the VNS was visible to others because Resident 1's body build was thin, the implant scar was visible in the upper left chest area, and the VNS is also palpable [can be touched] beneath the skin. [Resident 1] can point that out to others, and that's where magnet should be swiped should they have a seizure. Review of a 03/03/2022 hospital History and Physical note showed Resident 1 had a seizure disorder, with the last seizure on 12/27/2021, and a history of a VNS implant surgery. A 03/09/2022 medical provider note showed Resident 1 admitted to the facility on [DATE] with complex medical diagnoses, to include a recent neck surgery and a history of seizures. This progress note showed Resident 1 had a past surgical history of a stimulator - VNS. Review of a 03/09/2022 progress note showed Resident 1 was alert and oriented and able to make their needs known to staff. This progress note showed Resident 1's skin was intact and no documentation staff assessed for or identified the presence of a VNS. Review of 03/09/2022 admission assessments completed by Staff C, Licensed Practical Nurse/Unit Manager (LPN/UM), showed no documentation staff identified the implant scar or the visible and palpable VNS. An unsigned 03/09/2022 Admission Skin Assessment showed the same. A 03/11/2022 progress note written by Staff B, Director of Nursing, showed, [Resident 1] has a vagal device for seizures that we were unaware of and needed guidance for its use. Staff B wrote that Resident 1 wanted to explain the use of the VNS to the staff and have the staff follow the resident's direction. Staff B wrote, [Resident 1] had no signs or symptoms of seizure activity and the fact that we needed orders [for the VNS] was explained to [them] numerous times by numerous staff. The resident continued to shout in the hallway at this writer and [Staff C]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A 03/11/2022 progress note written by Staff C showed a call was placed to the neurologist, regarding resident's vagus nerve stimulator . Neurologist out of facility until Monday and unable to give orders until Monday [03/14/2022]. Staff C wrote that Resident 1 was unhappy with the resolve and Staff C told Resident 1 that they could leave the facility if unhappy with care in the facility. Staff C described, Resident was angry, aggressive, and walking the hallways. A 03/11/2022 6:13 PM progress note written by Staff K, Licensed Practical Nurse, showed that Resident 1, was having therapy in [their] room and had a small seizure. Staff described Resident 1 was unresponsive and that they started to use a vagal device while another nurse was on the phone with the medic. Resident 1 was transferred to the local hospital for evaluation. On 03/22/2022 at 9:13 AM, Staff K stated that on 03/11/2022, it was the first time they were assigned to care for Resident 1. Staff K stated that when they found the resident lying in bed, they shook the resident, who was unresponsive. Staff K stated that they sought the help of another LPN, Staff J, while they notified the doctor. Staff K stated that they were not present when Staff J, LPN, used the vagal device during Resident 1's unresponsive episode. Staff K stated that they received no training on seizure management or the role of a VNS and was assigned to Resident 1 on 03/11/2022, 03/12/2022 and 03/13/2022. On 03/22/2022 at 9:54 AM, Staff J stated that when they arrived at Resident 1's room on 03/11/2022, they found the resident in bed and breathing. Staff J stated that they were unfamiliar with Resident 1's medical background and care. Staff J was told by an aide that walked in the room that, if [Resident 1] became unresponsive there was like a magnet, you put it on the device on the left side of the chest. And that's what I did. I took the magnet and put it on the device [they] had in the chest. Staff J stated that they placed and maintained the magnet directly over the device on the left side of the chest until the medics arrived (an action that would turn off the VNS). Staff J stated that the vagal device was visible, like a pacemaker, under the resident's skin. I thought it was a pacemaker. I didn't know anything with this [vagal] device. Staff J stated that the aide told them where to find the magnet, it was inside the drawer of the bedside table. Staff J stated that they received no education on seizure management or the role of VNS therapy in seizure management. On 03/22/2022 at 2:38 PM, Staff L, LPN, stated that they were assigned to Resident 1's care on 03/11/2022 on night shift, when Resident 1 returned from the emergency room . Staff L stated, I've never worked with or seen it [VNS] before. When asked if they heard about the magnet therapy, Staff L stated, What do you mean magnet? Are they two different things [the magnet and the VNS]? I thought the VNS is the magnet you place on Resident 1's chest when they have a seizure. Staff L stated that Staff M, LPN, told them to, Just pass it on top of [Resident 1], like run it randomly around their chest, and then they will wake up from the seizure. Staff L stated that they received no training on seizure management or the VNS. A 03/12/2022 11:34 AM progress note showed staff received a phone call from a doctor at the local hospital, who instructed the staff to Swipe [the] magnet across the implanted pacemaker to LT [left] clavicle [collar bone] in case of seizure activity noted as needed. (continued on next page)

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	505195	A. Building B. Wing	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In a joint interview on 03/21/2022 at 11:35 AM with Staff C and Staff D (LPN/UM), Staff D stated that, Typically, I review the hospital records for a resident who comes in the building. I review the History and Physical and the Discharge Summary. Staff D stated that he took report from the hospital but did not recall a mention of the VNS. Staff D stated, The hospital didn't know it [VNS] existed because [Resident 1] had it in her purse. Staff C stated that they assessed Resident 1's skin integrity the day of admission, along with Staff D. Staff C related that Resident 1 lifted their shirt up, but did not observe the VNS scar location. Staff C stated that they became aware of the presence of the VNS on 03/11/2022, when Resident 1 told them that staff did not know about the VNS. Staff C stated that Resident 1 had the VNS locked in their purse. Staff C was asked to explain how an implant was locked inside a purse, if it was implanted under the skin. Staff C described the VNS as a small black box, and that Resident 1 told Staff C to place it over their left chest and that is when Staff C saw something sticking out like a pacemaker. On 03/21/2022 at 11:20 AM, Staff H, LPN, stated that they could not recall having any education on seizure management and did not know what a VNS was. At 11:35 AM, both Staff C and D stated that they received no education on seizure management and the role of a VNS. At 11:55 AM, Staff I, LPN, stated that they received no education on seizure management or what a VNS was. Staff J, LPN, stated at 12:15 PM that they could not recall when they last had seizure management education, and that a VNS was used by the therapy department on the patients. I've never heard about it. Review of the medical record showed no documentation the facility understood and identified the role of a VNS in seizure management, to include side effects associated with VNS use, throughout Resident 1's stay in the facility. Review of the medical record showed no documentation the facility identified and developed interventions for the role of and appropriate use of magnet therapy for VNS side effect management or first aid use. A 03/14/2022 progress note showed Resident 1 left the facility Against Medical Advice. On 03/18/2022 at 12:07 PM, Resident 1 stated, I was upset. It was a horrible experience. I feel it was the worst experience. I didn't care when I left if I didn't even have pain medications. I walked out. It wasn't worth my life. The above findings were shared with Staff A, Administrator, and Staff B. No further information was provided. Refer to F607, F655 and F760 Reference WAC 388-97-1060 (1).

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40297 Based on interview and record review, the facility failed to administer Lamotrigine (a seizure medication) according to physician orders for 1 (Resident 1) of 8 residents reviewed for seizures. This placed Resident 1 at significant risk for seizures and associated injuries. Resident 1 suffered a seizure and required a transfer to the hospital, after missing doses of Lamotrigine (a seizure medication) in a 3 day period. Findings included . Review of a 03/03/2022 hospital History and Physical in Resident 1's medical record showed the resident had a seizure disorder, with the last seizure on 12/27/2021. Review of a 03/09/2022 progress note showed Resident 1 admitted to the facility, was alert and oriented, and able to make their needs known to staff. A 03/9/2022 medical provider note showed Resident 1 admitted with complex medical diagnoses, to include a recent neck surgery and a history of seizures. This progress note showed Resident 1 was to continue with Lamotrigine and Zonisamide (a seizure medication). Review of Resident 1's March 2022 Medication Administration Record (MAR) showed that Lamotrigine 450 milligrams (mg) was scheduled for administration at 8:00 AM, and 300 mg at 8:00 PM. Review of this MAR showed no documentation staff administered the Lamotrigine doses as scheduled on 03/09/2022 at 8:00 PM, 03/10/2022 at 8:00 AM and 8:00 PM, and 03/11/2022 at 8:00 AM and 8:00 PM. A 03/09/2022 e-MAR (electronic MAR) note written at 10:26 PM showed, awaiting pharmacy supply. A 03/10/2022 at 12:29 PM e-MAR note showed, Not available, a 6:39 PM e-MAR note showed, None available, awaiting supply, and a 8:36 PM e-MAR note showed None in stock; awaiting pharmacy supply. Review of the medical record showed no documentation of the steps staff took to ensure Resident 1 received the Lamotrigine as scheduled when they identified the medication was not available for administration, like calling the pharmacy for availability. Review of the medical record showed no documentation the staff alerted the provider of the missed medication doses. On 03/18/2022 at 2:41 PM, a pharmacy collateral contact stated that the pharmacy notified the facility on 03/09/2022 at 9:30 PM via FAX and a phone call, of the pharmacy's concern with the high Lamotrigine dose, and the pharmacy's hold on supplying the medicine until the physician contacted the pharmacy to discuss the high dose. The Collateral Contact also stated that the pharmacy called the facility on 03/10/2022, and received no response from either the phone call message or faxes. Review of the medical record showed the facility was in receipt of a 03/10/2022 pharmacy fax that alerted the staff that the pharmacy must consult with the provider before dispensing the extremely too high, past the point of safety Lamotrigine dose. The fax showed no documentation staff acknowledged or acted upon the pharmacy alert. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A 03/11/2022 9:14 AM e-MAR note showed that Resident 1 was a, new admit, [and the medicine] not available. A 03/11/2022 11:17 AM progress note showed that staff placed a call to the pharmacy to ask why the Lamotrigine was not delivered. This note showed that the pharmacy, sent memo to the facility with concern that [Lamotrigine] dose is too high, past the point of safety, and wanted consult with provider before dispensing the medications. Staff notified the provider who then reviewed the Lamotrigine dose. This note showed the provider would call the pharmacy to inform them to continue the orders for the Lamotrigine as written. A 03/11/2022 provider progress note showed, I was called today by nursing in relation to this patient. Patient has a history of seizures and is on multiple seizure medicines. Patient also has chronic pain and some of these medications treat pain as well. The pharmacy did not send patients Lamotrigine because the dose is too high . I called [the] pharmacy and told them to send the Lamotrigine with the 1:00 PM delivery. It is not the role of pharmacy to just stop the medicine thus putting patient at risk for seizure activity. Pharmacy will send patient's prescription today by 1:00 PM. Another 03/11/2022 note by the provider showed they acknowledged Resident 1 has not received Lamotrigine to be given twice daily. A 03/11/2022 progress note written by Staff C, Licensed Practical Nurse/Unit Manager (LPN/UM), showed that Resident 1, has been yelling and cursing at staff regarding the missing Lamotrigine doses although calls have been made to pharmacy in order to obtain medication. Writer informed the resident sternly to ensure point was made that there are 3 options, Resident can go to hospital and be medicated in the ER [emergency room], resident can go AMA [Against Medical Advice] if unhappy with care in the facility, or resident could wait until pharmacy delivered the medication. This note showed that the staff called the pharmacy around 5:00 PM for an update on Lamotrigine and [pharmacy] reported medication would be delivered tonight. Resident was angry, aggressive and walking the hallways . DON [Director of Nursing] notified, physician notified, neurology notified. A 03/11/2022 progress note written by Staff B, DON, showed that Resident 1, was concerned that [they] hadn't received [their Lamotrigine as ordered. Staff B informed Resident 1 that if the resident were so concerned, that the facility could arrange for them to go to the hospital for treatment. Staff B assessed that Resident 1 had no signs or symptoms of seizure activity and that Staff C raised their voice to get Resident 1's attention and explain to the resident that if they were really concerned that the facility could send them home or back to the hospital. Staff B informed Resident 1 that the facility had no control over pharmacy deliveries and [the] Lamotrigine would be delivered sometime today. Staff B wrote that Resident 1 told them that the unavailability of the Lamotrigine was the facility's problem and that the facility would be in trouble because we were somehow responsible for the pharmacy delivery. Staff B again informed Resident 1 of the options of either discharging home or return to the ER [emergency room] if they were concerned. A 03/11/2022 provider note showed, I was called for [the] second time in relation to this patient. Patient was getting physical therapy and stopped talking and became unresponsive. Vital signs were unchanged and are stable. 911 was called and ER determined [Resident 1] had a seizure. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of 03/12/2022 progress notes showed that Resident 1 returned from the hospital at 12:05 AM. Resident 1 received 450 mg of Lamotrigine at the hospital, who also instructed the staff for the, Resident to continue taking [their] medications for seizure as scheduled. An 11:34 AM progress note showed staff received a phone call from a doctor at the local hospital, who ordered the staff to administer one time doses of Lamotrigine and Zonisamide as the resident did not receive Lamotrigine before going to hospital, and due to the recent seizure episode. The hospital doctor also gave orders that modified the current Zonisamide orders and kept the current Lamotrigine order. On 03/18/2022 at 11:31 AM, a Neurology Collateral Contact stated, Missing doses of Lamictal [Lamotrigine]? That's a big deal. Yes, it's a bit concerning, indeed. The Collateral Contact stated that because of Lamictal's short half-life (the time it takes for the amount of a drug's active substance in the body to reduce by half), missing doses placed Resident 1 at significant risk for harm. On 03/21/2022 at 11:30 AM, in a joint interview with Staff C and D (LPN/UM), Staff D acknowledged the facility received the 03/10/2022 pharmacy fax that notified the facility a provider needed to consult with the pharmacy before the release of the high-dose Lamotrigine. Staff D stated, Typically the Charge Nurse followed-up on the faxes that come in, and that the Night Nurse must have placed the pharmacy fax in the Medical Records box, probably didn't know what to do with it, and Medical Records then scanned it into the electronic record, and staff were unaware. Staff D stated that if a medication is not available, the nurses must call whoever is on-call to procure it. Staff D attributed the medication error to a failure in communication between the facility and the doctor and that, We could've prevented a citation, if they [the nurses] would've said something. They need to speak up. They have a legal obligation. The above findings were shared with Staff A, Administrator, and Staff B on 03/18/2022 at 4:31 PM. Staff B stated that Resident 1, missed 3 days worth of [Lamotrigine] doses. Staff B stated that the facility identified that, We found we had an issue with some of the medication delivery and so we looked at our whole system. The Pharmacy did not send the medications. The nurses did not report it [the missing doses] until two days later when the nurse managers discovered the resident did not get it [Lamotrigine]. We did find deficient practice in our system honestly. On 03/21/2022 at 1:24 PM, Staff B clarified that the facility discovered Resident 1 missed the Lamotrigine doses when the resident told Staff D on 03/11/2022. When asked if offering Resident 1 the option to leave the facility AMA or as a planned discharge addressed the missing doses of Lamotrigine, Staff A stated, No, it doesn't. A 03/14/2022 progress note showed that Resident 1 left the facility AMA. Resident 1 stated in an interview on 03/18/2022 at 12:07 PM, It was a horrible experience. I feel it was the worst experience. I didn't care when I left if I didn't even have pain medications. I walked out. It wasn't worth my life. Refer to F607, F655 and F684 Reference WAC 388-97-1060 (3)(k)(iii).