STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505098	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHUKSAN HEALTHCARE CENTER	1530 JAMES STREET BELLINGHAM, WA 98225

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** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that correct doses of medication were given for two of three residents (#1 and #2). This failure caused the resident's blood sugar to drop below normal and required hospitalization and placed residents at risk for poorly managed diabetic care and [MEDICATION NAME] management, potential for complications and decline in medical conditions. Findings Included . RESIDENT #1 Resident #1 admitted on [DATE] with a [DIAGNOSES REDACTED].#1 was to receive [MEDICATION NAME](short acting [MED]), inject four milliliters (ml's) with meals for elevated blood sugars beginning 02/12/2020. Review of a medication error investigation dated 02/22/2020 showed that Resident #1 was given the wrong unit maker (ml versus units) of [MED]. The physicians order showed the [MED] to be given in ml's instead of units. Too much [MEDICATION NAME] was given as a result. Order read, give 4ml of [MED] before meals, 4 ml's of [MED] [MEDICATION NAME] (short acting inuslin) was given subcutaneously at 8:00 AM. Resident was noted to be diaphoretic and shaky at 10:00 AM, blood sugar was rechecked at that time and read 36. Review of a witness statement dated 0[DATE]20 from the nurse who administered the incorrect dose of [MED], Staff A, Licensed Practical Nurse (LPN) showed that she thought the [MED] order was suspicious but that she knew Resident #1 had a history of [REDACTED]. She confirmed the order of give 4 mls before meals and saw that the dose had been given over the previous 10 days by different nurses thus administered the [MEDICATION NAME] to Resident #1. Staff A documented that Resident #1 was then taken to the dining room for breakfast. At 10:00 AM Resident #1 was diaphoretic and shaky and her blood glucose level was 36. Staff A continued to check her blood sugar every 20 minutes on her shift which varied from 36 to 61. Resident #1 was transported to the hospital at 6:45 with a blood sugar of 45. The conclusion of the investigation dated 02/25/2020 documented, After thorough investigation and root cause analysis, medication error was related to human error of mis-transcribing order into the electronic medical record as 4 ml's rather than 4 units on 02/12/2020. [MED] is always given in units not ml's. Resident #1 was given 100 times the dose of [MEDICATION NAME] that she was prescribed. In an interview on 03/04/2020 at 10:16 AM, Staff C, Registered Nurse, (RN) stated that he worked all with all of the residents in the building. Staff C stated that rights to medication administration are right resident, right medication, right time, right route and right dose. He stated that he heard about the medication error with Resident #1. Staff C continued to state that, Whenever I see [MED] I just know it is given in units and not given in ml's, people had signed off on the order, as a nurse we use judgement calls and [MED] is always in units. Obviously I was not using the 5 rights of medication administration but [MED] is never given in ml's . In an interview on 03/04/2020 at 10:42 AM, Resident #1's husband stated that his wife was on long and short acting [MED] and that they used vials to draw up the [MED] at home. He stated that he was informed of the error at 11:00 AM. He stated that after the hospital visit he was uneasy about her return to the facility but that after a conversation with Resident #1's primary care doctor he felt better about her return. He stated that when she first returned to the facility that he visited 3-4 time's day but he was not doing that anymore. In an interview on 03/04/2020 at 10:55 AM, Staff B, RN stated that when she was first hired she received two weeks training including medication administration. Staff B stated that the five rights to medication administration are the right medication, time, dose, route and resident. Staff B, stated that she did miss the ml on the order but that she knew that [MED] was given in units. Staff B stated that she was embarrassed that the mistake went through so many nurses. Staff B stated that when you input an [MED] order into the electronic medical record a drop down box allows you to change the unit of measurement to ml or units. In an interview on 03/04/2020 at 1:21 PM, the Director of Nursing Services (DNS) acknowledged that Resident #1 received too much [MED] and that she was hospitalized overnight. She stated that there was now a new diabetic management policy in place. She stated that she had followed up with all of the other nurses who had administered Resident #1's [MED] and that all of them administered her [MED] in units. She stated the electronic medical record defaults to ml's when inputting orders, thus the error. She stated all nurses should have beeb checking the rights for administration of medications but obviously that was not being done or the error would have been caught earlier. The DNS continued to state that the nurses in question were disciplined and they were to have on-going monitoring. The DNS continued to state that they immediately performed medication audits on all nurses, completed a required in-service for all nurses, placed a new monitoring system in place for all [MED] orders that were to be inputted into the medical record and changed Resident #1's to [MED] pens instead of vials. RESIDENT #2 Resident #2 was admitted on [DATE] and discharged on [DATE] with a [DIAGNOSES REDACTED]. Review of a medication error investigation dated 02/10/2020 showed Resident #2 had a stat (emergent) [MEDICATION NAME] level blood draw ordered on [DATE]. The Licensed Nurse (LN) was not able to follow up with the results and Resident #2 missed the [MEDICATION NAME] dose on 02/08/2020 and 02/09/2020. The error was found on 02/10/2020 when the [MEDICATION NAME] results from 02/08/2020 were not processed. The LN on day shift had checked the fax machine for the results, but they were not there and the LN passed this information on in report but the oncoming LN did not follow up. Review of a witness statement dated 02/08/2020 showed that Staff D documented, On 02/08/2020 Resident #2 had a stat [MEDICATION NAME] level blood test scheduled in the early morning. I took over for the evening shift. During report I must have either missed the information that the resident had a stat lab drawn or received/noted that information but did not register the need to follow up with the lab for results. Which were ultimately not received that evening. Resident's [MEDICATION NAME] medication remained on hold until the next blood draw more than a day later. In an interview on 03/04/2020 at 2:31 PM Staff E, RN stated that all labs are done in the morning and the results are faxed back so the LN can follow up the results with the physicians. Staff E stated when an order of [MEDICATION NAME] is received, the medication is placed on the MAR and placed in the running [MEDICATION NAME] flow sheet which showed the lab results, the new order to be taken and the next lab draw. In an interview on 03/04/2020 at 3:25 PM, Staff F, Resident Care Manager stated that she found the [MEDICATION NAME] error on Resident #2 on 02/10/2020 because during the week one of her responsibilities was to monitor the [MEDICATION NAME] book for follow up and accuracy. She stated Resident #2 should have had a new order for [MEDICATION NAME] on 02/08/2020, so she had missed doses. Reference (WAC) 388-97-1060 (3)(k)(iii)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.