STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505362	A. BUILDING _____ B. WING _____	06/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VIEW RIDGE CARE CENTER	5129 HILLTOP ROAD EVERETT, WA 98203

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 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** Based on interview and record review, the facility failed to ensure accurate pharmaceutical services/procedures when dispensing and administering medications for one of three residents (#1) reviewed for pharmaceutical services. Failure to: 1) accurately process a physician's orders [REDACTED].#1 was harmed when she fell and sustained a [MEDICAL CONDITION] after receiving a 400% increase of the physician ordered dose 29 times before the facility discovered the medication error. Upon discovering the medication error, the facility failed to document the error in the resident's clinical record and staff failed to consider whether the multiple overdoses were contributory to the resident sustaining a [MEDICAL CONDITION]. Findings included . Definitions: Ombudsman (Ombud): An ombud was a representative from the Washington State Long-Term Care Ombudsman Program, which was an organization that advocated for residents of nursing homes, adult family homes, and assisted living facilities. The purpose of the program was to protect and promote the Resident Rights guaranteed these residents under Federal and State law and regulations. Ombuds were trained to receive complaints and to resolve problems in situations involving quality of care, use of restraints, transfer and discharge, abuse and other aspects of resident dignity and rights. [MEDICATION NAME] - an anticonvulsant medication that was used to prevent [MEDICAL CONDITION], it was also used to relieve nerve pain. Side effects of [MEDICATION NAME] (from WebMD.com) included drowsiness, dizziness, loss of coordination, tiredness, blurred/double vision, unusual eye movements, or shaking (tremors). RESIDENT #1 The resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to her admission Minimum Data Set assessment, dated 04/03/2020, she had no cognitive impairment, and she required 1-person physical assist with walking. Review of the Skilled Nursing Facility Transfer Orders, dated 03/27/2020, revealed under the Unchanged medications section of the orders, was an order for [REDACTED]. to give 1200 mg three times daily. Review of an investigation summary, dated 04/06/2020, revealed Resident #1 had two falls on 04/06/2020. The second fall that the resident had on this day, she sustained a left [MEDICAL CONDITION]. The investigative report findings did not find abuse or neglect because the resident was independently up and walking and getting ready for bed when her legs gave out and she fell . There was no mention at all in the investigation that there had been a medication error related to excessive [MEDICATION NAME] being administered to the resident three times a day from 03/27/2020 - 04/06/2020, for a total of 29 incorrect doses. Review of a Medication Error Report, dated 04/07/2020, discovered on 04/06/2020 Resident #1 had received [MEDICATION NAME] 1200 mg (milligrams) three times daily from 03/27/2020 - 04/06/2020, when the physician's orders [REDACTED]. The form had a block to Describe impact of error on resident, including assessment, to which staff wrote in None. The resident remained alert and oriented, participated with therapies, was not sedated, no complaints of weakness, her vital signs were stable and there was no orthostatic (where the blood pressure was taken in a lying position, then sitting, then standing positron) blood pressure was done. There was no mention at all of the falls or the fall with fracture, even though these falls occurred on the same day the medication error was discovered by staff. In the spot on the form for family notification, staff wrote in the patient was notified, but not family or the resident's power of attorney. Review of other medication error documentation revealed during the investigation, the facility identified that the medication card documentation did not match from the card to the physician order [REDACTED]. Review of a nurse practitioner's progress note, dated 04/06/2020, revealed the resident was evaluated that day for a chief complaint/nature of presenting problem of a fall, and for follow-up of multiple comorbidities including a fall. The note indicated the resident was also evaluated that day for increased somnolence (somnolence per Wikipedia was alternatively called sleepiness or drowsiness, and was a state of strong desire for sleep, can be accompanied by lethargy, weakness, or lack of mental agility), that she recently had some medication adjustments, tapering down of [MEDICATION NAME] as well as [MEDICATION NAME] (opiate pain medication). Note: this note did not mention anything at all about the resident's medication errors of receiving excessive doses of [MEDICATION NAME]. Review of a nursing progress note, dated 04/06/2020 at 11:15 PM, revealed the resident fell twice that shift, and the nurse had notified the resident's daughter of the fall and the plan of care. Note: this note did not mention anything at all about the resident's medication errors of receiving excessive doses of [MEDICATION NAME]. Review of a hospital history and physical examination [REDACTED]. It sounds like the fall was mechanical, though she is very sleepy and not able to provide details before falling back asleep. In a phone interview on 06/01/2020 at 3:05 PM, the resident's daughter/Power of Attorney, stated she had not been able to visit her mother during the stay at the nursing home due to the COVID-19 pandemic, but she talked to her on the phone. The daughter stated her mom had been telling her on the phone that the nursing home was giving her more medications than her usual. The daughter stated her mother had been telling her she could not stay awake and she was always very sleepy. The daughter stated ever since her mother went into the nursing home, her mother had told her she was always feeling overly sleepy, which is why she started investigating what was going on because she wasn't allowed to go visit due to COVID. The daughter stated prior to hospitalization , she had been the one to manage her mother's medications and she knew exactly what her mother was taking because she set up her medication cassettes for her at home. The daughter stated her mother had been taking [MEDICATION NAME] 300 mg, 1 tablet, three times daily. The daughter stated after she brought her mother home from the nursing home after the surgery, her mother fell again and re-broke her left hip and her left wrist. In an interview on 06/02/2020 at 3:19 PM, the Administrator was asked why the medication errors had not been documented in the resident's clinical record, she stated she didn't know that was required. The Administrator was asked why the medication errors had not been included in the fall incident investigation, she stated they didn't feel the medication error was related to the fall because the medication error occurred 12 days prior to the fall. In a phone interview on 06/04/2020 at 9:47 AM, Resident #1 stated with her first fall (on 04/06/2020) she just lost her balance and fell and was wobbly. She said with the second fall (same day, on 04/06/2020) she didn't remember much about that. She said she knows she felt dopey, that she just didn't feel right, she felt wore out, that she felt she could just go to sleep at any time. She stated she hadn't always felt like that, and she just didn't know what was going on. She stated she just didn't care because she was just so tired. She stated she did not know about her medications because her daughter was in charge of her medications. She said she was tired all the time, and all she wanted to do was lay down and sleep all the time. She stated she told her daughter she was tired all the time, and that she hurt. She stated since her daughter couldn't come and visit her, she just had to trust that they all knew what they were doing for her. She stated it was all pretty foggy for me. The resident denied any knowledge at all of the medication errors. In a phone interview on 06/04/2020 at 10:20 AM, Staff A, Pharmacist, stated the pharmacy processed the initial [MEDICATION NAME] order on 03/27/2020 for 300 mg, three times a day. Staff A stated they had also gotten a copy of the Medication Administration Records (MARs) for that same order, and the pharmacy realized the physician's orders [REDACTED]. Staff A stated they put a note on the prescription on 03/27/2020 and faxed it back to the nursing home. Staff A stated they weren't confident in the note being seen. Staff A stated the

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.

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F 0755 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) pharmacy's fax was all electronic, and nothing really happened with it. Staff A did state that on 03/30/2020 and 03/31/2020 the nursing home requested multiple times for a refill on the [MEDICATION NAME], but it was too early for refills based on the original correct order of 300 mg three times daily. In a phone interview on 06/05/2020 at 3:10 PM, Staff A stated initially on 03/27/2020 the pharmacy had filled the initial [MEDICATION NAME] order with 42 tablets of 300 mg each. Staff A stated the initial supply of [MEDICATION NAME] provided should have lasted for two weeks, but the nursing home was requesting a refill after only three days. Review of Ombuds notes, dated 05/13/2020, revealed the resident's daughter had reported the nursing home had called her about two falls on 04/06/2020 and that the resident had sustained a possible fracture and was sent to the hospital. There was no report at all of any medication errors. The Ombud notes also revealed the residents' daughter had reported to the Ombud that during the daughters' phone calls with her mother, her mother had reported several times that she was unusually tired and that she did not feel right. In a phone interview on 06/05/2020 at 3:10 PM, the resident's daughter/Power of Attorney, reported the nursing home never reported the medication errors to her, but that they should have because her mother was confused and wasn't capable of managing her own medications. The residents' daughter stated her mother was now in a different nursing home, and was still quite confused at times. Reference: (WAC) 388-97- 1300 (1)(a)(b)(i)(ii)(c)(i)(ii)(4)(d)