STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505262	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHORELINE HEALTH AND REHABILITATION	**2818 NORTHEAST 145TH STREET SEATTLE, WA 98155**

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent the development and worsening of an avoidable pressure ulcer for one of two residents sampled (Resident #2). This failure led to an open pressure wound for Resident #2 that worsened to an unstageable wound under a medical brace and caused pain. Findings included . Review of the facility pressure ulcer prevention policy showed the following interventions for skin pressure ulcer prevention: 1. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. 2. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device. 3. Monitor regularly for comfort and signs of pressure-related injury. Evaluate, report and document potential changes in the skin. 4. Review the interventions and strategies for effectiveness on an ongoing basis. The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury (Ulcer) definition and stages include: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable [DIAGNOSES REDACTED] of intact skin. Intact skin with a localized area of non-blanchable [DIAGNOSES REDACTED], which may appear differently in darkly pigmented skin. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without [DIAGNOSES REDACTED] or fluctuance) on the heel or ischemic limb should not be softened or removed. Review of facility records showed Resident #2 admitted to the facility in July 2020 for rehabilitation after a fall with fractures at home. Resident #2 needed extensive assistance from two people for all activities of daily living. Review of the facility admission skin assessment for Resident #2, dated 07/09/2020, showed no abnormalities or no open pressure wounds were identified for Resident #2 on admission to the facility. Review of the facility skin risk assessment, dated 07/10/2020, on admission to the facility showed Resident #2 was at risk for an alteration in skin integrity mainly due to immobility. On 07/10/2020, an abduction hip brace was placed for dislocation of hip in the emergency room after Resident #2 fell in the facility. (An abduction brace holds the femur/thighbone in the hip socket, and is used to prevent excessive motion in the hip to promote healing.) Review of a facility physician note, dated 07/13/20, showed the abduction hip brace was to be on Resident #2 at all times except for hygiene. Review of progress notes, dated 07/16/2020, six days after the brace was applied for Resident #2 showed Staff F, a licensed nurse, had noted two open skin areas on Resident #2's lower back, 6 cm (centimeters) by 5 cm total, caused by the hip brace rubbing. The wound areas were red, and a treatment order, dated 07/16/2020, for cleansing and a dressing was obtained. The progress note also showed: open areas to lower back x 2, areas appeared to have been caused from left hip brace rubbing area; area as a whole is red and indurated (hard) measuring 6 cm x 5 cm, there are 2 open areas within the indurated area, the upper open area measuring 2.5 cm x 3 cm and the lowermost open area measures 1 cm x 1 cm; no drainage noted to either area, resident denies pain upon palpation to area; received new order to cleanse areas and apply foam dressing daily. Review of the facility care plan, dated 07/09/2020, 07/22/2020, 07/28/2020, and 07/29/2020, for Resident #2 showed the following interventions for Impaired Skin Integrity: consult wound nurse, monitor for symptoms of infection, monitor for redness of skin especially over bony prominences, air mattress on bed, reposition in wheelchair, weekly skin checks. The resident's care plan did not mention the medical device (hip brace) or the increased need for monitoring of the device for pressure or rubbing on the skin. The care plan did not mention any other interventions to prevent pressure ulcers from the device that was applied to Resident #2 on her front and back hip and up the abdomen and back above the waist. During an interview on 08/31/20 at 9:00 a.m., Staff E, a licensed nurse, stated that Resident #2's hip brace was made of hard plastic, was secured with straps, and the brace extended above the waist. Staff E stated that there was no skin irritation at first, but then the skin became irritated so the staff put clothing under the brace. Staff E stated the skin still got irritated, especially when Resident #2 was up in the wheelchair so they put a pillow behind her in the chair, The wound then needed a treatment and dressing. It got irritated in bed too. I checked it daily. Therapy staff pointed out the wound was open. Size of nickel, red no slough (dead skin tissue) at first. The brace was big for her. A treatment was added for debridement (removal of dead tissue). There was no evaluation of the size of the brace for Resident #2, it seemed it was too big for her. Review of the facility July 2020 medication and treatment records for Resident #2 showed the following orders: -An order to Monitor skin under brace every day was started on 07/18/2020 (8 days after the brace was applied and 2 days after the wound was discovered); -Weekly skin check documentation: Skin check. Yes = skin issue No = No skin issues, one time a day every Fri Y = Yes, N=No: On 07/10/2020 was marked as no (no skin issues); 07/17/2020 not charted; 07/24/2020 marked N (although there was an open wound), 08/07/2020 marked N (although there was an open wound); -Pressure mattress started on 07/27/2020 (11 days after wound found); -Turn every two hours started on 07/30/2020 (14 days after wound found); August 2020: monitor skin under the brace was still only daily (not every shift). During an interview on 09/01/20 at 1:00 p.m., the Director of Nursing (DNS) stated that she expected skin care with a brace device to prevent pressure ulcer should include skin inspected at least every shift, The facility is working on a new skin care system. And you should see a progress note every time the staff do a wound treatment. Review of the physician note, dated 07/16/2020 for Resident #2 showed: Pressure ulcer of unspecified part of back, stage 2, Plan: covered with foam dressing to protect from rubbing against hip brace. Wound on lumbar spine noted by nurse approximately 2.5 x 3 cm and 1 x 1 with [DIAGNOSES REDACTED] in surrounding tissues. No pain to touch. Wound bed is dry. It appears to may have been caused by hip brace rubbing on skin.

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

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) [DIAGNOSES REDACTED]. There was no further wound description in the facility record for Resident #2 until 07/24/2020, eight days later. when documentation by Staff E showed: wound open and tender with no further description of the wound or further interventions implemented to prevent worsening of the pressure ulcer. Review of facility medicare meeting notes, dated 07/23/2020 and 08/06/2020 showed Resident #2 had a pressure wound from the medical brace rubbing. There was no further description of the wound or updated plan to prevent worsening of the pressure wound on the back of Resident #2. Review of a facility progress note, dated 07/25/2020, nine days after discovery of the wound, showed Resident #2 was alert and confused per baseline, able to make her needs known. Complained of mild pain on lower back with movement. Tylenol given. Lower back wound dressing changed as ordered. Wound bed with 100% slough (dead tissue), peri-wound skin red, scant drainage on old dressing, no foul odor. Affected area is painful to touch during treatment. Further review of the facility progress notes showed a note dated 07/26/2020, Alert and able to make her needs known. Complained of back pain mostly at wound site. Stated that it is usually pain with movement during cares or touch. Routine pain regimen administered with good relief. Lower back wound measured-4.5 cm x 2 cm, wound bed with 100% slough, mild redness noted at peri-wound, small amount of yellowish drainage noted on old dressing, wound is tender to touch. On call physician notified about current condition of the wound. New treatment order received and started. New order received to remove abductor brace while in bed due to pressure and friction on the wound. On 07/27/2020, eleven days after the discovery of the pressure wound, a physician order [REDACTED]. A physician note, dated 07/27/2020, showed Pressure injury of left lower back, unstageable .Offload pressure. Review of the following facility wound monitoring progress notes between 07/27/2020 and 08/10/2020 showed inconsistent measurements, limited changes in interventions, and that the pressure wound was worsening: 07/27/2020- wound on back measured 4.5 cm by 1.5. It has yellow slough on it. It is also painful to her. She has order for air mattress and she was put on it. She is to off load throughout the day and night. The wound is now getting a debridement treatment to the wound base. Doing labs and looking for possible infection to the wound on the spine from the brace to the left leg that she had been wearing. 07/28/2020- wound bed is covered with slough (dead tissue), redness noted surrounding wound; brace in place to left hip. 07/29/2020- Wound measured 4.5 x 2 cm, wound bed with 100% slough (dead tissue), redness on peri-wound skin, scant drainage on old dressing. 07/30/2020- wound healing consult note-[MEDICATION NAME] Spine Wound Medical Device Related Pressure Injury Pressure Ulcer 4.5 cm x 2 cm total 9 square cm 76-100 percent slough-unstageable-treatment for [REDACTED]. 07/31/2020- wound bed continues to be slough covered with redness and warmth noted to peri-wound; resident has complaints of pain with wound care. 08/01/2020- the wound is still yellow in color. 08/02/2020 wound on mid low back spine region. There is yellow slough in the wound bed. There is some redness around the perimeter of the wound. It is tender to the touch. 08/03/2020 wound to spine continues with slough (dead issue) to wound bed and redness around wound. 08/04/2020 wound care done to pressure area on mid back, wound bed continues to be slough covered, continues with noted redness and warmth surrounding wound; brace is in place to left hip. 08/05/2020- Lower back wound dressing changed as ordered. Wound bed is still covered with 100% slough, tender to touch. 08/06/2020-physician note: Pressure ulcer on lower back -wound is slowly improving but still with 100% slough, does not want back brace-uncomfortable due to scoliosis. 08/06/2020- wound-slough remains-unstageable pressure ulcer-not healed-4.1 cm x 2.8 cm scant drainage, periwound red. 08/08/2020- Wound is tender to touch, 100% slough on wound base, mild redness on peri-wound(surrounding) skin. Scant drainage noted on old dressing. 08/09/2020- lower back wound dressing changed as ordered. Wound still has 100% slough at wound base with mild peri-wound [DIAGNOSES REDACTED]. Wound area is very tender to touch. 08/10/2020- wound on back hurting. During an interview on 08/26/2020 at 11:00 a.m., Staff B, a licensed nurse who worked on the evening/night shift while Resident #2 had the open wound, stated he knew nothing about any skin wound for Resident #2. During an interview on 08/28/2020 at 1:00 p.m., Staff F, a licensed nurse who was the first to document the wound on 07/16/2020, stated that the hip brace for Resident #2 extended up mid-back, was made of plastic and had Velcro to tighten and to keep it on which took two people to do. The brace was supposed to be off only for hygiene. Staff F also stated that Resident #2 had pain from an open wound on her back from the brace rubbing on the skin. Staff F also stated that the first time she saw the wound, it was about 5 cm by 4 cm and had hard yellow slough on the wound with redness around the outside and that the wound was unstageable from the first time it was identified, When you touched the wound you could see the pain on her face, it hurt. There was padding inside the brace, but no other pressure relief interventions at that time. During an interview on 08/28/20 at 1;20 p.m., Staff C, licensed nurse, stated that the open pressure wound on Resident #2's back was related to the hip brace, and staff checked the skin daily, The wound was definitely painful. Especially during treatment. During an interview on 08/25/20 at 12:20 p.m., a family member/emergency contact for Resident #2 stated that she received many complaints from Resident #2 about pain caused by the brace and the open wound on her spine. Review of emergency room records, dated 08/10/2020, showed Resident #2 was sent to the emergency room (ER) after a fall and arrived in the ER with an unstageable pressure ulceration on her back. The facility failed to timely implement, evaluate and monitor interventions to relieve and prevent pressure ulcers on the skin under the medical device/hip brace for Resident #2 that resulted in an avoidable unstageable pressure wound on the back spine area and pain. Reference (WAC) 388-97-1060(3)(b)
F 0760 **Level of harm -** 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 two of two residents sampled (Resident #1 and #2) remained free of significant medication errors. This failure led to wrong medications being administered to Resident #1 which contributed to blood pressure/mental status changes that required emergency room intervention and an unplanned hospital stay. This failure also led to Resident #2, who had repeated falls, receive narcotics that had been discontinued, and placed the resident at risk for more confusion/falls. Findings included . RESIDENT #1 The facility Policy and Procedure for Medication Administration showed the facility expected the following: Medication must be administered in accordance with the orders, including any required time frame. The individual administering medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. Checking identification band; b. Checking photograph attached to medical record; and c. If necessary, verifying resident identification with other facility personnel. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Review of facility medical records showed Resident #1 was admitted to the facility in July 2020 for rehabilitation. Records on admission to the facility showed Resident #1's blood pressure was 116/84 and pulse rate 76, and was cognitively alert and oriented times three. Resident #1 ambulated with a walker and had previously lived alone at home. Review of the facility record showed vital signs for Resident #1 had blood pressure readings ranging from 130/70 to 140/90 from admission on 07/24/20 until a medication error on 07/26/20. Review of the admission physician orders [REDACTED]. Review of a facility progress note, dated 07/27/2020, showed the nurse on duty, Staff A, administered wrong medications to Resident #1 after allegedly attending to another resident with a potential emergency. The physician was notified and an order to monitor Resident #1 every 30 minutes was started, check for confusion, and an order to notify the physician if blood pressure systolic (top number) was less than 100 and diastolic (bottom number) was less than 55 or pulse less than 65. The progress note by Staff A also showed Resident #1's initial blood pressure reading (taken after the wrong medication administration) was 128/68 with a pulse= 86. The resident's blood pressure then dropped to 118/70, and dropped again to 88/58 with dizziness. Resident #1 was sent to the hospital emergency room for change in condition. Review of the facility investigation showed Resident #1 had been given 5 medications by Staff A, a licensed nurse, on 07/26/2020 at around 9:00 pm: [MEDICATION NAME] 12.5 mg (for high blood pressure), [MEDICATION NAME] 0.1 mg (for high blood pressure), [MEDICATION NAME] 300 mg (an anticonvulsant), [MEDICATION NAME] 100 mg (treats high blood pressure), [MEDICATION NAME] 10mg (antidepressant). The investigation showed that Staff A, LN, had interrupted her medication pass to tend to a coughing resident, returned to the medication cart, and then mistakenly gave the medications to Resident #1. Staff A immediately realized the error. Resident #1 was transferred to the emergency room and treated for [REDACTED]. The LN was reeducated for medication administration and had subsequent medication administration reviewed. Review of the 07/24/2020 admission physician orders [REDACTED]. Review of the physician progress notes [REDACTED].#1 was hospitalized for [REDACTED]. The physician note also showed, Resident #1 had been given wrong medications at the facility, resulting in a hospitalization for four nights 07/26/20 to 07/30/20. Resident #1 arrived in the emergency room with a blood pressure of 90/60 that changed with the 90 down to the 70's, which had to be corrected with intravenous fluids for the abnormally low blood pressure which was medication-induced. Resident #1 also had medication-induced changes in mental status with somnolence (drowsiness) which was also resolved when the blood pressure was corrected. Other symptoms induced by the medication error were dizziness and fast heart rate, also corrected at the hospital. During an interview on 08/28/2020 at 6:00 p.m., Staff

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F 0760 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) A, a licensed nurse, stated that she had administered the wrong medications to Resident #1 during a busy time when she got distracted with a possible emergency with another resident. Staff A stated that she would review the five rights of medication administration again if she poured medications and became interrupted in the future. The facility failed to ensure Resident #1 was free of significant medication errors when the facility staff administered five medications that were not ordered by the physician to Resident #1. This significant medication error of wrong medications and wrong resident resulted in significant low blood pressure and mental status changes, that led to an emergency room transfer for treatment and a four night stay in the hospital. RESIDENT #2 Review of facility records showed, Resident #2 admitted to the facility in July 2020 for rehabilitation after a fall and fractures at home. Review of the facility progress note dated 07/29/2020, shortly after admission to the facility, showed Resident #2 was alert and oriented x 2-3, and able to make her needs known. Resident #2 had some back pain with movement during cares or positioning. Routine Tylenol was administered as ordered with good relief per patient. Offered prn [MEDICATION NAME] or [MEDICATION NAME] but resident declined those medications. Review of the physician's orders [REDACTED]. Review of a facility progress note by Staff C, licensed nurse, dated 08/05/2020, showed Resident #2 was alert and confused per baseline and able to make her needs known. Resident #2 expressed back pain with movement. Offered pain medication, but the resident declined and stated, I don't want to take any narcotic. Routine Tylenol was administered as ordered with good relief per patient. Review of the physician note, dated 08/06/2020, showed [MEDICAL CONDITION], Plan - stop narcotics for now. The physician note also showed Resident #2's POA (Power of attorney) stated he wanted the narcotics stopped because Resident #2 had increased confusion when she took narcotics in the hospital. Resident #2 had some confusion and [MEDICAL CONDITION] since admit to facility, but today appears to be more exacerbated. In discussing with POA, he feels strongly about having the resident on narcotics. He tells me resident had similar presentation in the hospital with narcotic use requiring at least four days before she began to clear. Her [MEDICATION NAME] had been stopped a while ago, but she continues on [MEDICATION NAME] for back pain. He asked for this to be stopped as well. Review of facility progress note by Staff E, a licensed nurse, 08/07/2020 showed Staff E spoke to the legal representative for Resident #2 who was more adamant about telling me that his Mom can't have narcotics. He said this is from his Mom taking them, and then going goofy. I (Staff E) told him the [MEDICATION NAME] had been discontinued. The [MEDICATION NAME] had been discontinued. I said she was confused again. I assured him no narcotics had been given. During an interview on 08/26/2020 at 2:20 p.m., the legal representative for Resident #2 stated he told the facility not to give narcotics to Resident #2 for pain because it caused her to be confused in the hospital. Review of a facility progress note, dated 08/08/2020 by Staff C, a licensed nurse on day shift, showed Resident #2 was alert and confused, able to make her needs known, had back pain and noted to have frequent episodes of moaning. Staff C offered [MEDICATION NAME], a narcotic, multiple times during the shift but Resident #2 declined to take any and she stated I don't want to take any [MEDICATION NAME] Tylenol was administered as ordered with some relief. (Staff C offered [MEDICATION NAME], a narcotic that was discontinued 07/31/20). Review of the facility progress note, dated 08/08/2020 by Staff B, a licensed nurse on night shift, showed Resident #2 complained of pain, [MEDICATION NAME] and [MEDICATION NAME] given with relief (both discontinued medications). Review of the facility investigation, dated 08/14/2020, showed Staff B, a licensed nurse, administered both [MEDICATION NAME] and [MEDICATION NAME] to Resident #2 on 08/08/2020, even though the narcotic medication orders had been discontinued. The investigation showed Staff B obtained the medications out of the medication cart without checking the medication administration record. During an interview on 08/25/2020 at 4:20 p.m., the Director of Nursing (DNS) stated that the narcotics were still in the medication cart after being discontinued and had not been disposed of yet by the nurses when the medication error happened. The DNS stated that Staff B had not checked the Medication Administration Record [REDACTED]. During an interview on 08/26/2020 at 11:00 a.m., Staff B, a licensed nurse, stated that Resident #2 was yelling with foot pain and he told her he would give her some medication for the pain, but did not discuss what he would give. Staff B stated he went to the medication cart narcotic book and got two pain pills for Resident #2, one [MEDICATION NAME] and one [MEDICATION NAME] and gave them to her. Staff B stated he did not check the Medication Administration Record [REDACTED]. Staff B stated he was in a hurry to treat the pain and had not checked the current medication orders in the Medication Administration Record [REDACTED]. Review of a facility progress note dated 08/09/2020 by Staff C, a licensed nurse, showed Resident #2 was alert and confused, responds to yes and no questions. Moans and grimaces with movement or positioning. Offered [MEDICATION NAME] but Resident #2 adamantly declined. Routine Tylenol administered with some relief. (Again, Staff C offered Resident #2 a narcotic pain medication that had been discontinued.) The facility staff failed to follow physician's orders [REDACTED].#2 after the medications had been discontinued per physician orders. Reference (WAC) 388-97-1060(3)(k)(iii)
F 0773 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician immediately of laboratory results that fell outside of clinical reference ranges for one of one residents sampled for critical blood test results (Resident #2). This failure led to delayed treatment for [REDACTED].#2 was then subsequently hospitalized for [REDACTED]. Findings included . According to Lippincott, Williams, and Wilkins 2013, [MEDICAL CONDITION] is an abnormally low hemoglobin and level of circulating red blood cells decreases the blood's oxygen carrying capacity. [MEDICAL CONDITION] is most often due to excess bleeding or inadequate red blood cell production. The lab test helps determine the severity and cause of the [MEDICAL CONDITION]. Red blood cell transfusion is indicated for signs and symptoms of [MEDICAL CONDITION] such as a critical oxygen carrying deficit. Review of facility records showed Resident #2 admitted to the facility in July 2020 for rehabilitation. Resident #2 needed extensive assistance from two people for all activities of daily living and had a [DIAGNOSES REDACTED]. Review of facility physician notes by Staff D, a nurse practitioner, showed Resident #2 had lab blood test results on 07/21/2020- hemoglobin 8.8 started iron for [MEDICAL CONDITION]; and again on 07/29/2020- hemoglobin 8.2 stable [MEDICAL CONDITION]. Review of a facility physician note, dated 08/07/2020, showed Resident #2 more confused today and refusing her am medications. During my exam, patient is alert and interactive, but very confused when it comes to details about her care. When I asked her if she declined her AM meds, patient denies declining her am meds. She then agreed to take her meds. She appears to have difficulty following commands and has word salad. She had assisted fall from her bed overnight. She was found attempting to get out of bed, then assisted to the floor by staff. No reported injury from fall. Patient has no recollection of the fall. Review of a facility progress note by Staff E, a licensed nurse, dated 08/07/2020, showed Staff D, a nurse practitioner, had ordered a STAT (immediate as soon as possible) blood count (CBC) for that evening and the laboratory was notified. Review of the facility physician orders for Resident #2 showed a STAT CBC blood test ordered on [DATE] for lethargy and confusion. During an interview on 08/31/2020 at 9:00 a.m., Staff E, a licensed nurse, stated the nurse practitioner ordered a STAT blood test for Resident #2 on Friday 08/07/2020. Staff E stated that she notified the lab who drew the blood around 8:50 pm that evening and STAT blood tests usually took about 4 hours then we report to physician, I put Resident #2 on nursing alert and told the nurse on the next shift about the STAT blood test. I did not hear anything else about it until Monday morning 08/10/2020 after she fell again and was found lying next to her bed confused and restless and we sent to her to the emergency room . That is when the nurse practitioner found the critical lab result in the computer from Friday. Review of the facility policy for laboratory tests, provided by the facility Director of Nursing(DNS), showed the Attending Physician will be notified of the results of diagnostic tests. During an interview on 09/01/2020 at 1:00 p.m., the DNS stated the staff should notify the physician immediately for any critical or abnormal lab result, The nurse did not communicate about the lab test. We are working on a system that each shift should report when labs are pending. During an interview on 09/01/2020 at 12:40 pm, Staff B, the licensed nurse on duty at night when the STAT lab was drawn, stated he did not know a lab was pending or ordered to be STAT the night of 08/07/2020 for Resident #2. During an interview on 08/28/2020 at 1:20 p.m., Staff C, a licensed nurse who also worked on that floor at the time of the STAT lab for Resident #2 stated that he did not have knowledge that a STAT blood test was ordered. Staff C stated, We now have system in place for tracking labs. During an interview on 08/31/2020 at 9:00 a.m., Staff E, a licensed nurse who was present when the STAT lab was ordered, stated that three days later on Monday 08/10/2020, Staff E sent Resident #2 out to the emergency roiagnom on [DATE] when she was confused and restless and had another fall. When speaking to the nurse practitioner at that time on 08/10/2020, the practitioner found the STAT lab results from Friday 08/07/2020 with a critical value. Review of the laboratory report for Resident #2 showed a STAT blood test was drawn at the

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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 0773 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) facility on 08/07/2020 at 9:53 p.m. with Critical Low results: Hemoglobin 3.1 (normal 11.3 to 15.5); Hematocrit 10 (normal 34 - 46); Red Blood cells 0.94 (normal 3.7 to 5.10). The lab report showed the critical results were called to the facility at 10:19 p.m. on 08/07/2020 and the report printed at 10:21 p.m. The lab report had a fax date at the top of 08/07/2020 at 10:25 p.m. According to The Lippincott Manual of Nursing Practice 2014, the most common cause of [MEDICAL CONDITION] in adults is chronic stomach/intestinal tract bleeding and symptoms of [MEDICAL CONDITION] generally develop when the hemoglobin falls below 11.0. These symptoms can include dizziness and fatigue. During an interview on 08/31/2020 at 10:30 a.m., Staff D, a nurse practitioner, stated that she was concerned about Resident #2 on Friday 08/07/2020 because of her increased confusion and back pain after a fall she had at the facility that day. Staff D stated that she ordered a STAT (immediate) blood count to be done by the facility at that time. In addition, Staff D stated Resident #2 had stable [MEDICAL CONDITION] and some low blood values during her stay at the facility. Staff D further stated she did not receive the critical lab blood work results done on 08/07/2020 until Monday 08/10/2020, almost 72 hours after the STAT was ordered. Staff D found it on a computer after being called about Resident #2's fall on 08/10/2020. The lab value for Resident #2's was critically low and Resident #2 was sent to the emergency room . Review of emergency room and hospital records, dated 08/10/2020 to 08/20/2020, showed Resident #2 had a hemoglobin of 3.4 (normal is 11.5-15.5) and RBC of 1.10 (normal 3.8-5.0) upon arrival to the emergency room (critical) and was found to have stomach/intestinal tract bleeding from ulcers that led to acute blood loss [MEDICAL CONDITION]. The resident's blood pressure was 99/43 and 97/51 per the ER report. Resident #2 received three units of blood for significant [MEDICAL CONDITION] at the hospital to bring the hemoglobin up to 7.9. Resident #2 also had blood in the feces at the emergency room . Resident #2 also received intravenous iron at the hospital for the critical [MEDICAL CONDITION]. Resident #2 also had acute heart failure from the [MEDICAL CONDITION] and low blood cell count that resolved after the blood [MEDICAL CONDITION] in the hospital. The resident was admitted to the special care unit in serious condition at 4:30 pm on 8/10/2020 according to the hospital record. The facility failed to report the critical lab result of low blood cells/hemoglobin after a STAT blood test on 08/07/2020 which led to delayed treatment and hospitalization needed for bleeding and critical interventions to correct heart failure. Resident #2 experienced a ten day hospitalization due to delayed treatment. Reference (WAC) 388-97-0320(1)(b)