STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505510	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON CARE CENTER - FEDERAL WAY	135 SOUTH 336TH STREET FEDERAL WAY, WA 98003

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate and thoroughly investigate alleged medication errors, injuries of unknown origin, and falls for three (#1, 2 & 3) of four residents who had incidents that required investigation. The facility's failure to initiate and/or thoroughly investigate these identified incidents, detracted from staffs' ability to accurately identify causative factors, and precluded staff from identifying and timely implementing interventions to prevent reoccurrence. These failures placed residents at risk for continued medication errors, falls, injury, and a decline in health. Findings included . Refer to CFR 483.45(f)(2), F-760, Free From Significant Medication Errors RESIDENT #1 Resident #1 admitted to the facility on [DATE]. According to the 05/15/2020 Quarterly Minimum Data Set (MDS, an assessment tool), the resident was cognitively intact, had multiple medically complex [DIAGNOSES REDACTED]. The assessment also indicated Resident #1 received diuretic therapy on seven of seven days during the assessment period. Record review showed Resident #1 was followed by the Pulse Heart Institute (PHI), a Cardiac Care Clinic, for management of her [MEDICAL CONDITION]. According to a 06/03/2020 PHI encounter note the resident was assessed to be in fluid volume overload with [MEDICAL CONDITION] past the knees, with weeping, blisters and wounds to bilateral lower extremities. The document alleged Diuretics were not adjusted up as ordered at her last follow up. In an interview on 06/19/2020 at 2:31 PM, Staff A, Administrator, stated that PHI had called the facility with concerns regarding Resident #1. Staff B, at this time, confirmed PHI had contacted her alleging medication errors, the clinic alleged that orders from the resident's 04/15/2020 appointment were not implemented by the facility. Staff B indicated she investigated the allegation, but found no errors. In an interview on 06/19/2020 at 2:37 PM, after reviewing Resident #1's physician's orders [REDACTED]. When asked why these errors were not identified when she investigated the allegation, Staff B indicated she only reviewed the order sheet, but did not look at the MAR, resulting in the input and transcription (computer entry) errors not being identified. Staff B stated at that time she did not complete a medication error form, because she did not see an error. When asked if she felt the allegation was accurately and thoroughly investigated Staff B stated, No. RESIDENT #2 Resident #2 admitted to the facility on [DATE]. Review of the May 2020 physician's orders [REDACTED]. According to the May and June 2020 Treatment Administration Records (TAR) the resident received the treatment daily from 05/15/2020 through 06/18/2020 (34 days). Record review showed no indication what type of wound Resident #2 had, or how it was acquired. In an interview on 07/08//2020 at 12:03 PM, when asked how Resident #2 acquired a wound to her left inner thigh, Staff B reviewed the resident's record and stated I don't know. When asked what the facility's policy was when a resident was identified with an injury of unknown origin, Staff B stated, Investigate to determine the cause, rule out abuse/neglect, and implement interventions to prevent reoccurrence. Review of the May 2020 incident log, showed no entry related to Resident #2's left inner thigh wound. When asked if the injury of unknown origin was investigated Staff B stated, No. RESIDENT #3 Resident #3 admitted to the facility on [DATE]. According to the 06/13/2020 Admission MDS, the resident had moderate cognitive impairment, [DIAGNOSES REDACTED]. A 06/08/2020 provider note indicated Resident #3 was admitted to the hospital .with complaints of hip pain secondary to a fall after experiencing syncopal episode. X-rays showed a left [MEDICAL CONDITION] and the resident underwent [REDACTED]. The cause of the syncopal episode that resulted in the fall was .thought to be the result of [MEDICAL CONDITION], dehydration and [MEDICAL CONDITION]. Review of the facility's incident log showed Resident #3 had a non-injury fall on 06/21/2020 at 12:45 AM, and a fall on 07/02/2020 at 8:15 PM that resulted in a Deep laceration. According to the 06/21/2020 fall investigation, a staff member was walking by Resident #3's room and noticed the resident lying supine on the floor next to his bed. Assessment revealed no apparent injury and the resident was assisted back to bed. When asked what happened Resident #3 indicated he was trying to go to his car. Per the investigative summary, on 06/22/2020 Resident #3 had a chest x-ray performed due to a alteration in respiratory status which showed pleural effusion. The resident was subsequently started on [MEDICATION NAME] (a diuretic), and supplemental oxygen. The 06/21/2020 investigation concluded the fall was reasonably related to the resident's impaired cognition, impulsiveness, and change in (respiratory) condition. Review of the investigative documents showed under the environmental factors, the box for poor lighting was not checked. Review of the investigation showed no indication staff determined whether the light was on or off at the time of the fall, or considered its relevance as a potential contributing factor. The investigation section .physiological factors, showed the box for new medication /change in dose within last 30 days was not checked. However, review of the June 2020 MAR indicated [REDACTED]. The boxes provided to record the resident's blood sugar and orthostatic blood pressures were not completed. There was no indication staff asked the resident if he experienced dizziness when rising to self transfer, or whether he had another syncopal episode. Additionally, the investigation failed to mention/address the resident's left [MEDICAL CONDITION], and non-weight bearing status as potential contributing factors. During a telephone interview on 07/30/2020 at 4:00 PM, when asked if the facility should have: identified the resident had an insulin increase two days prior to the fall; checked the resident's blood sugar to rule out the presence of elevated or decreased blood sugar as potential contributing factors, given it was determined to be a causative factor in the fall that resulted in the resident's hospitalization ; identified the resident's left [MEDICAL CONDITION] and non-weight bearing status as predisposing factors for a fall; identified environmental factors, such as, if the light was on or off at the time of the fall; assessed the resident for orthostatic hypertension; determined if the resident experienced dizziness with position changes; and determined if the resident had another syncopal episode prior to the fall, Staff A stated, Yes. When asked if any of the above was assessed or addressed in the investigation Staff A stated, No and acknowledged the investigation was not thorough or accurate. According to the 07/02/2020 Incident summary, staff heard a loud noise coming from resident's room. Upon entering the room the resident was observed lying on his back near the end of the bed with his legs extended straight out and his head near the dresser. Assessment revealed a 2.5 inch laceration to the back of the resident's head, and he complained of right hip pain 10/10. Per the assessment range of motion was intact to the right hip and first aid was provided to stop the bleeding from the laceration. The resident had a blood sugar of 123, oxygen saturation of 94% on two liters of oxygen, and a irregular pulse of 149. The resident was subsequently sent to the hospital for further evaluation. The fall investigation identified contributing factors to the fall as: recent wt gain; increased lower extremity [MEDICAL CONDITION]; pleural effusions/infiltrates (congestion) in the lungs with shortness of breath; and recent dose changes to the resident's [MEDICATION NAME] (a diuretic) order. The investigation concluded It is reasonable to believe fall occurred due to acute change in medical status pertaining to [MEDICAL CONDITION] congestion and weakness. However, record review showed the resident was started on [MEDICATION NAME] 20 mg daily for three days on 06/22/2020 due to shortness of breath. On 06/25/2020 the resident was assessed by the provider, with direction to Continue [MEDICATION NAME]. Review of the June 2020 MAR indicated [REDACTED]. Resident #3 was seen by the provider again on 06/29/2020, with and order to Continue [MEDICATION NAME]. The resident then received [MEDICATION NAME] 20 mg from 06/29/2020 to 07/02/2020. According to 07/02/2020 nurse's notes: at 10:58 AM the resident was identified with a 4 lbs wt gain in 24 hours, and assessed with [REDACTED]. Review of the July 2020 MAR indicated [REDACTED]. Additionally, the new order for [MEDICATION NAME] 40 mg twice

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) daily, was input to start on 07/03/2020 at 6:00 AM, resulting in Resident #3 not receiving his evening dose of [MEDICATION NAME] 40 mg as ordered. Although the investigation concluded that the resident's increased [MEDICAL CONDITION], weight, [MEDICAL CONDITION] congestion and recent [MEDICATION NAME] dose changes were the underlying cause of the fall, there is no indication that the facility thoroughly reviewed the resident's record to identify or assess why the resident's fluid volume stats was worsening. This resulted in facility staff failing to identify that on six occasions during the nine days preceding the fall, staff failed to administer the resident's [MEDICATION NAME] as ordered. The failure to identify the multiple medications errors preceding the fall detracted from staff's ability to accurately determine the root cause, and precluded them from implementing meaningful interventions to prevent reoccurrence. During an interview on 07/31/2020 at 3:16 PM, Staff B acknowledged the above medication errors. When asked if the medication errors should have been identified through the investigative process Staff B stated, yes. REFERENCE WAC: 388-97-0640(6)(a)(b). .
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure services provided, met professional standards of practices for three (#s 1, 2 & 3) of five residents reviewed. Nursing staffs' failure to obtain, follow, and/or timely implement physicians's orders (POs), and to only sign for tasks that were completed, resulted in medication errors and placed residents at risk unmet care needs, and negative outcomes. Findings included . Refer to: CFR 483.25, F-684 Quality of Care 483.45(f)(2), F-760, Significant medication error RESIDENT #1 Resident #1 had a 03/19/2020 order to obtain weights (wts) every Monday and Thursday, with direction to notify the Physician for wt gain of 3 pounds (lbs) or more. Review of the April and May Medication Administration Records (MARs) showed on the following occasions the resident had a greater than 3 pound wt gain with no indication nurses notified the Physician as ordered: 1) 04/24/2020-270 lbs; 04/27/2020- 280.2 =10.2 lbs wt gain. 2) 05/04/2020- 279.6 lbs; 05/07/2020-285 lbs =5.4 lbs gain 3) 05/18/2020-284 lbs; 05/21/2020- 291 lbs = 7 lb gain. During an interview on 06/23/2020 at 12:00 PM, when asked if there was any indication the Physician was notified of the above wt gains of greater than 3 lbs, Staff B stated, No and acknowledged the nurses failed to follow the PO. Resident #1 had a 02/26/2020 order for [MEDICATION NAME] a (cardiac medication) with instruction to hold for (systolic blood pressure less than) 100 or pulse (less than) 60. According to the April and May 2020 MARs staff assessed the resident with a pulse of less than 60 on 04/02/2020, 04/03/2020, 04/10/2020, 04/11/2020, 04/12/2020, 04/20/2020, 05/09/2020, and 05/29/2020, but administered the medication despite instructions to hold the medication. During an interview on 06/19/2020 at 12:46 PM, when asked if the nurses administered the medication in accordance with the PO Staff B stated, No. Record review showed a 04/15/2020 order, to decrease to Metroprolol to 12.5 mg once daily, secondary to [MEDICAL CONDITION] (slow heart rate.) Review of the April 2020 MAR indicated [REDACTED]. On 04/15/2020 at 9:49 AM, orders were obtained to give [MEDICATION NAME] (a diuretic) this afternoon at 2:00 PM, then switch to [MEDICATION NAME] to 60 mg at 7:00 AM and 30 mg at 2:00 PM for three days. Then decrease to 40 mg BID (twice a day) unless otherwise directed. Review of April 2020 MAR indicated [REDACTED]. Instead the 60 mg was administered on 04/16/2020 at 3:50 PM, contrary to th directions of 30 mg at 2:00 PM. In an interview on 06/19/2020 at 3:20 PM, Staff B acknowledged nursing failed to give the 60 mg of [MEDICATION NAME] on 04/15/2020 as directed. When asked why Resident #1 was administered 60 mg of [MEDICATION NAME] on the evening of 04/16/2020, when 30 mg was ordered Staff B explained, because the 60 mg was not administered on the evening of 04/15/2020, Staff C, Resident Care Manager, likely scheduled it for 04/16/2020 to make it up. When asked if an order was obtained to do so Staff B stated, No. According to the April 2020 MAR, nursing administered 60 mg of [MEDICATION NAME] at 5:58 AM and again at 7:00 AM During an interview on 06/19/2020 at 12:47 PM, when asked why the resident was administered an additional 60 mg of [MEDICATION NAME] at 5:28 AM, Staff B, indicated it resulted from a data entry error. When asked if the resident had an order for [REDACTED]. Staff B stated nursing should have, called the doctor and clarified the order but did not. In a telephone interview on 06/18/2020 at 1:18 PM, Resident #1 indicated she had not worn her TED (compression) hose in three weeks or more. Review of the Treatment Administration Record (TAR) on 06/19/2020, showed nursing had signed that they applied the TED hose daily from 06/01/2020 through 06/19/2020. On 06/19/2020 at 1:55 PM, Resident #1 was observed in her room, without her TED hose on, (confirmed by Staff E, Resident Care Manager) despite the nurse having signed that, she ensured the TED hose were in place that morning. Staff E then confirmed that he had not seen TED hose on Resident #1 in awhile. On 06/24/2020 Staff A, Administrator, provided statements from the four nurses: Staff H, Licensed Practical Nurse (LPN); Staff I, Registered Nurse; Staff J, LPN; and Staff K, LPN, who had signed that they ensured the TED hose were in from 06/01/2020 through 06/19/2020. The nurses acknowledged that either: they signed without validating the TED hose were in place, or signed then attempted to place them but the resident declined. During an interview on 06/26/2020 at 11:41 AM, Staff B expressed it was the expectation that nurses did not sign for a task until after it is completed. Record review showed a 04/15/2020 order for daily weights. Review of the April 2020 MAR indicated [REDACTED]. During an interview on 06/19/2020 at 12:00 PM, when asked who was responsible to ensure the daily wts were obtained Staff B stated, nursing and acknowledged that they failed to do so. RESIDENT #2 Resident #2 had a 05/20/2020 order for a vascular consult. Record review revealed no indication that the facility ever scheduled the appointment. Resident #2 was discharged to the hospital on [DATE], and diagnosed with [REDACTED]. When asked if she expected the appointment to be scheduled before 40 days later Staff B stated, yes. and indicated it was nursing's responsibility to ensure the appointment was scheduled, but they failed to do so. RESIDENT #3 Review of Resident #3's 07/02/2020 progress notes revealed the following: at 11:20 AM the nurse documented the resident was given an additional dose of 20 mg [MEDICATION NAME] (a diuretic); and at 11:35 AM nursing received a new order to start [MEDICATION NAME] 40 mg twice daily. Review of the July 2020 MAR indicated [REDACTED]. Additionally, the new order for [MEDICATION NAME] 40 mg twice daily, was to start on 07/03/2020 at 6:00 AM, which resulted in the 07/02/2020 afternoon dose of [MEDICATION NAME] 40 mg not being administered. During an interview on 07/31/2020 at 3:16 PM, Staff B acknowledged that nursing either failed to document or failed to administer the additional dose of [MEDICATION NAME] 20 mg and acknowledged because the nurse who processed the [MEDICATION NAME] 40 mg twice daily order set it to start on 07/03/2020, Resident #3 did not receive his afternoon dose on 07/02/2020. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii) .

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** Based on observation, interview, and record review, the facility failed to ensure residents received the care and services they were assessed to require, in accordance with professional standards of practice, and, the comprehensive person-centered care plan. The facility failed to ensure two (#s 1 & 3) of three residents reviewed received services related to [MEDICAL CONDITION] monitoring and management, and two (#s 1 & 2) of three residents reviewed received services related to non pressure skin issues. These failures resulted in harm to Resident #1 and placed other residents at risk for a decline in medical status and quality of life related to unmet care needs. Findings included . Refer to CFR: 483.21(b)(3)(i), F-658, Services Provided Meet Professional Standards 483.25, F-692, Nutrition/Hydration Status Maintenance 483.45(f)(2), F-760, Residents are free of Significant Med Errors RESIDENT #1 Resident #1 admitted to the facility on [DATE]. According to the 05/15/2020, Quarterly Minimum Data Set (MDS, an assessment tool), the resident was cognitively intact, had multiple medically complex [DIAGNOSES REDACTED]. The record review showed Resident #1 had a 01/08/2020 order for [MEDICATION NAME] (a diuretic) 30 mg (milligrams) twice daily for [MEDICAL CONDITION], and was followed by Pulse Heart Institute (PHI), a Cardiac Care Clinic, for [MEDICAL CONDITION] management. The resident also had a 03/19/2020 order to obtain wts every every Monday and Thursday, and notify the MD (Doctor) of a wt gain of three or more pounds (lbs). According to a 03/28/2020 [MEDICAL CONDITION] care plan (CP), staff were directed to monitor, document and report signs and symptoms of [MEDICAL CONDITION] including: dependant [MEDICAL CONDITION] of legs and feet; periorbital (around the eyes) [MEDICAL CONDITION]; SOB (shortness of breath) upon exertion; orthopnea (SOB when lying flat); distended neck veins; and wt gain unrelated to intake. In a telephone interview on 06/17/2020 at 12:27 PM, when what the facility's process or method was for [MEDICAL CONDITION] monitoring, Staff B, Director of Nursing, explained that [MEDICAL CONDITION] assessments should include, type of [MEDICAL CONDITION], brawny (non-pitting) versus pitting. If [MEDICAL CONDITION] was present, nurses should assess the degree of [MEDICAL CONDITION] (0-4+) and indicated nurses would document these assessments in their progress notes During an interview on 06/19/2020 at 12:00 PM, for clarification, Staff B was asked if 2+ pitting pedal (foot/ankle) [MEDICAL CONDITION], had the same clinical significance as 2+ [MEDICAL CONDITION] that extended from the foot

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) up to the mid thigh? Staff B stated, No and indicated nurses should also document the extent of the [MEDICAL CONDITION], acknowledging that failure of nurses to document the extent, could detract from their ability to determine if the [MEDICAL CONDITION] was improving or worsening. According to a 02/25/2020 PHI consult Resident #1 had 0 [MEDICAL CONDITION]. A 04/02/2020 provider note stated the resident had +2 [MEDICAL CONDITION] to bilateral lower extremities (LEs). Review of the weight summary flowsheet for the two weeks preceding 04/02/2020, showed the following: 3/19/2020, 273 lbs (pounds); 03/26/2020, 272.5 lbs; and on 04/02/2020, 285 lbs. (12.5 lbs wt gain in seven days.) Review of the progress notes showed no indication staff identified the significant wt gain or notified the Physician as ordered until 04/05/2020, three days later. The 04/05/2020 nurses note acknowledged Resident #1's 12.5 lbs wt gain in one week, and indicated the ARNP (Advanced Registered Nurse Practitioner) was notified, and a reweigh would be obtained. The note did not include an assessment of the resident, her [MEDICAL CONDITION], or fluid volume status. On 04/06/2020 the resident was re-weighed at 282.2 lbs, confirming the resident had a 10 lbs wt gain. A 04/07/2020 progress note confirmed the 10 lb wt gain and stated, Increased wt due to pre-existing +2 [MEDICAL CONDITION] on bilateral lower extremities. ARNP notified. No explanation was provided as to how the resident gained 10 lbs in just over a week, if the [MEDICAL CONDITION] was pre-existing. Again, there was no indication staff assessed the resident, or her [MEDICAL CONDITION]. The resident's progress notes were reviewed up to 04/15/2020. There was no further mention of the resident's wt gain, or indication staff were assessing/monitoring her [MEDICAL CONDITION]. On 04/15/2020 Resident #1 had a telehealth consult with PHI. Per the consult Resident #1 reported Over the last month she had increases in swelling to her bilateral LEs (lower extremities) despite wearing TED (compression) hose, and that (her legs) were so swollen and tight, they hurt. The PHI practitioner concluded Resident #1 was .volume overloaded with increase (sic) swelling of bilateral LE and wt gain of 20 lbs (from prior visit on 02/25/2020, which PHI had a documented wt of 260 lbs). PHI recommended: 1) Daily wts for the next week, if wt gain > (greater than) 3 lbs in one day or 5 pounds in 3 days, please call our office immediately. 2) Increase [MEDICATION NAME] to 60 mg in the AM and 30 mg in the PM for three days, then give [MEDICATION NAME] 40 mg twice daily, unless otherwise directed. Review of the April 2020 MAR indicated [REDACTED]. The order for daily wts was not initiated until 04/20/2020, five days later. Additionally, the parameters directing staff when to notify the PHI clinic of wt gain, were not transcribed. In an interview on 06/26/2020 at 11:41 AM, Staff B acknowledged the six [MEDICATION NAME] medication errors and indicated they were due to data entry errors. According to Staff B, the delay in implementation of of the daily wts was because the nurse understood Daily wts for the next week to mean, start them the next week. When asked how staff would know when to notify the MD, in absence of the ordered parameters Staff B stated, they wouldn't. A 04/15/2020 acute CP directed staff to Assess and Document [MEDICAL CONDITION] on all shifts. Review of the progress notes showed staff failed to assess and document Resident #1's [MEDICAL CONDITION] on all shifts, as she was assessed to require. On the shifts the resident's [MEDICAL CONDITION] was assessed, staff only documented e.g. continues with 2+ [MEDICAL CONDITION] to bilateral lower extremities. The extent of the [MEDICAL CONDITION] was not assessed. During an interview on 06/19/2020 at 12:00 PM, Staff B acknowledged the nurses failed to asses and document the resident's [MEDICAL CONDITION] all shifts and consistently failed to document the extent of [MEDICAL CONDITION]. Staff G, Regional Nurse Consultant, explained the facility had moved away from assessing [MEDICAL CONDITION] to determine fluid volume status related to [MEDICAL CONDITION], due to inconsistencies in how nurses graded the [MEDICAL CONDITION]. Staff G indicated the facility was now utilizing weights, as they were more accurate. However, Staff G did acknowledge that both the comprehensive and acute CPs directed staff to assess and monitor the residents [MEDICAL CONDITION]. Review of the daily wts from 04/20/2020 through 04/30/2020, showed the facility only obtained the wts on six of the 11 days. During an interview on 06/19/2020 at 12:00 PM, when asked if the resident was being weighed at the frequency she was assessed to require Staff B stated, No and acknowledged that could result in a delay in identification of wt gain. Review of the May 2020 Medication Administration Record [REDACTED]. A review of Resident #1's May 2020 wts showed, on 05/04/2020 the resident weighed -279.6 lbs. The next wt was obtained was 05/07/2020 at 285 lbs, showing a 5 lbs wt gain. Record review showed no indication facility staff identified the wt gain, or notified the doctor as ordered. On 05/13/2020 Resident #1's [MEDICATION NAME] was decreased to 40 mg daily secondary to a critical BUN (Blood, Urea, Nitrogen) level of 74. On 05/18/2020 Resident #1 weighed- 284 lbs. The next wt obtained on 05/21/2020 was 291 lbs, showing a 7 lb wt gain in three days, and a 12 lb wt gain since 05/04/2020. Again, record review showed no indication staff identified the wt gain, notified the doctor as ordered, assessed the resident, or considered the correlation of the decreased [MEDICATION NAME] and subsequent increased wt. During an interview on 06/23/2020 at 12:30 PM, when asked if there was any indication staff identified the above wt gains, assessed the resident, and notified the doctor, Staff B stated, No. On 06/02/2020 Resident #1 was seen by PHI via telehealth. According to the encounter note the resident reported .an increase in [MEDICAL CONDITION] to her bilateral LEs. She is quite miserable with her lower extremity swelling .experiences some orthopnea when lying flat .she was (also) noted to be experiencing hypervolemia (fluid overload) back in April at this visit .(Resident #1) is in need of IV (intravenous) diuretics and perhaps direct admit. PHI subsequently ordered an additional 40 mg of [MEDICATION NAME] to be given 06/02/2020, and scheduled an in person appointment for 06/03/2020. Review of Resident #1's progress notes from 05/27/2020 to 06/02/2020 (the 7 days preceding the 06/02/2020 PHI consult) revealed no indication any nurse assessed the resident's [MEDICAL CONDITION], fluid volume status, or identified the resident's weight gain until after the PHI appointment. A 06/02/2020 4:12 PM, nurses note stated, .Cont(inues) with BLE (bilateral LE) [MEDICAL CONDITION]. The nurse did not grade or evaluate the extent of the [MEDICAL CONDITION]. On 06/03/2020 Resident #1 was seen at PHI. They assessed the resident with Significant wt gain .increase in swelling and bloating .her legs are openly weeping, [MEDICAL CONDITION] to above the knees, JVD (Jugular Vein Distension) is elevated to the ear .gets short of breath with talking. Right (lung) base crackles noted. Both legs are weeping with blisters .wounds present. According to the 06/03/2020 Report of Consultation the resident was [MEDICATION NAME] with 100 mg of IV [MEDICATION NAME], and returned to the facility with recommendations for a two liter per day fluid restriction, and to increase [MEDICATION NAME] to 40 mg twice daily. Review of the June 2020 Treatment Administration Record (TAR) showed upon return Staff D, Licensed Practical Nurse, conducted Resident #1's weekly head to toe skin check. According to the documentation the resident had no new wounds, her skin was warm, pink, and dry to touch. Staff D did not identify the weeping legs, [MEDICAL CONDITION] to above the knees, blisters, or wounds, that the PHI clinic noted to the resident's LEs just hours before. In a telephone interview on 06/11/2020 at 7:14 PM, when asked if her legs were still swollen Resident #1 stated, Yes .they're terrible, they're so tight they hurt. When asked if she was familiar with the term weeping Resident #1 said, yes and indicated both legs were still weeping and then volunteered I have sores .one behind my left knee, down on my left leg, and I think on my right leg, but I'm not sure. Resident #1 indicated her legs had been that way for a couple of weeks or so, maybe a little more. Record review showed no indication staff had identified any weeping or wounds to Resident #1's LEs. According to the June 2020 TAR, Resident #1 skin checks were performed on 06/10/2020 and 06/17/2020 by Staff D. On each occasion Staff D assessed the resident had no new wounds, and the resident's skin was pink, dry and intact. Additionally, staff were signing daily, that they applied TED (compression) hose to Resident #1's LEs, which indicated Resident #1's legs were observed daily. In a telephone interview on 06/18/2020 at 1:18 PM, Resident #1 stated that her legs were still swollen, weeping, painful and that her wounds were still present. When asked if she was sure the wounds were still present Resident #1 stated, Yeah .I am looking at it, and indicated it was on her left LE. When asked how she was tolerating the placement of her TED hose Resident #1 laughed and stated, I haven't worn them in three weeks or more. When asked why the resident stated, They don't bring them anymore . On 06/19/2020 at 1:55 PM, Staff E, Resident Care Manager, was requested to perform a skin check on Resident #1. Upon entering the room Resident #1 was observed reclined in her electric wheelchair, with no TED hose or socks on and her lower extremities exposed. Two weeping ulcers were clearly visible. Staff E assessed the upper wound to the left shin to be 2 cm (centimeters) x 2 cm x 0.1 cm, with heavy serous (straw colored fluid) drainage, and a yellow wound base. The lower ulcer was assessed to be 0.5 cm x 0.5 cm x 0.1 cm, with heavy serous drainage and a yellow wound base. Staff E confirmed Resident #1's LEs were weeping, and noted a path of fluid from the mid shin ulcers, around the back of the calf that ended at the resident's achilles . where multiple drops of serous fluid were hanging and dripping onto the wheelchair. While performing the skin check Resident #1 stated the nurses and the aides were aware of the weeping and the wounds. When asked what nurse specifically was aware of the wounds Resident #1 stated, (Staff D) .she does my checks .she did one last night after we got off the phone, she wanted to know what we talked about. After exiting the residents room Staff E acknowledged he had not seen TED hose on her awhile. On 06/24/2020 Staff A, Administrator, provided statements from the four nurses who had documented from 6/01/2020 through 06/19/2020 that they applied Resident #1's TED hose. Each nurse acknowledged that Resident#1 had not been wearing the TED hose. During an interview on 06/23/2020 at approximately 3:20 PM, Staff D stated that she was the primary evening shift nurse for Resident #1 and confirmed she performed the resident's skin

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	505510	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON CARE CENTER - FEDERAL WAY	135 SOUTH 336TH STREET FEDERAL WAY, WA 98003

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) checks on 06/03/2020, 06/10/2020, 06/17/2020 and assessed there were no new wounds, and the skin was pink, dry and intact. Staff D was then informed; on 06/03/2020 the PHI clinic had identified weeping [MEDICAL CONDITION], blisters, and wounds to Resident #1's LEs just hours before she performed a skin check; on 06/11/2020, and 06/18/2020 Resident #1 reported via telephone that her legs were weeping and she still had wounds (both one day after her documented skin checks); and that today the weeping and wounds were validated. Staff D was asked if she actually performed the skin checks. Staff D stated, I guess so. When asked if she had ever falsely signed for a skin check that she did not do Staff D stated. Yes later elaborating I am busy, so I click (sign of as complete) through stuff and go back later and fix it. Facility staffs' pattern of failure to: consistently monitor, accurately assess, and document resident #1's [MEDICAL CONDITION]; apply TED hose to manage [MEDICAL CONDITION] as the resident was assessed to require; consistently obtain, evaluate, address and report wt variances to the physician as ordered; and failure to perform skin checks as ordered, resulted in delayed identification, intervention, and treatment of [REDACTED]. These failures resulted in harm to Resident #1. RESIDENT #3 Resident #3 admitted to the facility on [DATE]. According to the 06/13/2020, admission MDS assessment, the resident had moderate cognitive impairment, [DIAGNOSES REDACTED]. According to the facility's 06/06/2020 admission assessment, and provider notes dated 06/08/2020, and 06/12/2020, Resident #3 had no [MEDICAL CONDITION]. Record review revealed the following nurse's notes: 06/22/2020 12:56 AM .left leg swelling noted. There was no indication where the swelling was located (upper leg/lower leg) or the type (pitting/non-pitting) or extent of the swelling; 06/23/2020 left leg with [MEDICAL CONDITION] .[MEDICAL CONDITION] remains plus 3 The note did not indicate the extent of the [MEDICAL CONDITION].; 06/29/2020 4:15 PM .increased swelling to the left lower leg from upper thigh to toes . The assessment failed to grade the [MEDICAL CONDITION] or identify the type; and 07/02/2020 10:58 AM .BLE (bilateral LE) [MEDICAL CONDITION] 2+ . Again, the assessment failed to identify the extent of the [MEDICAL CONDITION]. During an interview on 06/19/2020 at 12:00 PM, Staff B was asked if 2+ pitting pedal (foot/ankle) [MEDICAL CONDITION], had the same clinical significance as 2+ [MEDICAL CONDITION] that extended from the foot up to the mid thigh? Staff B stated, No and stated nurses should also document the extent of the [MEDICAL CONDITION], acknowledging that failure of nurses to document the extent, could detract from their ability to determine if the [MEDICAL CONDITION] was improving or worsening. RESIDENT #2 Resident #2 admitted to the facility on [DATE]. Review of the May 2020, physician's orders [REDACTED]. According to the May and June 2020 TAR the resident received the treatment daily from 05/15/2020 through 06/18/2020 (34 days). Record review showed no indication that staff obtain initial measurements, assessed the wound base, amount and type of drainage, or determine what type of wound it was. Additionally, there was no indication the facility assessed or monitored wound weekly after identification. In an interview on 07/08//2020 at 12:03 PM, when asked how Resident #2 acquired a wound to her left inner thigh, Staff B reviewed the resident's record and stated I don't know. When asked if there was any indication that the facility obtained initial measurements, and assessed the wound characteristics. Staff B stated, No. When asked if the facility staff measured and assessed the wound weekly to determine if it was improving or declining Staff B stated, No. REFERENCE: WAC 388-97-1060 (1) .
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents with significant weight gain were identified, assessed, and that interventions were implemented, for two (#s 1 & 3) of three residents reviewed for nutrition. The facility's failure to consistently obtain and evaluate resident weights, resulted in unidentified significant weight gain, delayed interventions, and placed residents at risk for potential negative outcomes. Findings included . According to the Skin and Nutrition Outline, dated 04/2019, staff were directed to obtain weights on new admits weekly for four weeks, assess residents with significant weight loss or gain, defined as: 3% in one week; 5% in one month; 7.5% in three months; or 10% in six months. The document indicated when a significant weight change was identified, staff would identify the root cause of the loss/gain by assessing: labs; [MEDICAL CONDITION]; special diet; wounds; and change of condition. RESIDENT #1 Resident #1 admitted to the facility on [DATE], and according to the 05/15/2020, Quarterly Minimum Data Set Assessment tool (MDS), the resident was cognitively intact, had multiple medically complex [DIAGNOSES REDACTED]. According to the .alteration in nutrition . care plan (CP), revised 12/30/19, the goal was to have gradual weight (wt) loss 0-2 pounds (lbs) per week as desired towards improved body Mass Index, but no significant wt loss e.g. greater than 5% in 30 days or 10% in 180 days. Review of the resident's May 2020 physician's orders [REDACTED]. Record review showed the following wts: 04/24/2020, 270 lbs; 04/27/2020, 280.2, (10.2 lbs wt gain); 04/29/2020, 279 lbs; 05/04/2020, 279.6 lbs; 05/07/2020, 285 lbs, (5.4 lbs gain); 05/11/2020, 183; 05/18/2020, 284 lbs; 05/21/2020, 291 lbs, (5 lb gain); and 05/25/2020, 291 lbs. Record review revealed no indication the Physician had been notified of the wt gains greater than three pounds as ordered. A 04/27/2020 5:22 PM, progress note stated, WEIGHT WARNING .Weight fluctuation likely due to changes in diuretics over last week. Continue with weights as ordered. Recent [MEDICAL CONDITION] exacerbation. Record review confirmed on 04/15/2020, the resident was diagnosed with [REDACTED]. After the [MEDICATION NAME] increase the resident's wt trended down (as expected) from 279.8 lbs on 04/16/2020 to 270 lbs on 04/24/2020. However, there was no indication facility staff considered, that in the presence of increased diuretic dosing, a 10 lbs wt gain in three days, was not expected and should be investigated. A 05/11/2020 5:26 PM nurses note, stated WEIGHT WARNING .Followed in weekly nutrition meeting-see notes. Review of the 05/13/2020 Skin and Nutrition Review (SNR), indicated the resident was on a Consistent Carbohydrate Diet (CCD) and received Boost and liquid protein daily. The assessment used the 05/11/2020 wt of 183 lbs. Under review of condition changes section it stated, Does not sleep in bed anymore and addition comments section was blank. There was no indication the Interdisciplinary Team (IDT) which included a registered dietician (RD), identified, assessed, or addressed Resident #1's 13 lbs wt gain since 04/24/2020. Additionally, the assessment inaccurately indicated the resident was on a CCD diet, when the resident was actually on a low sodium diet. Similar findings were noted for the 05/20/2020 SNR. The IDT inaccurately stated the resident was on a CCD diet, and failed to identify, assess, or address the resident's 5.18 % wt gain in less than 30 days. Under condition changes . staff again documented Does not sleep in bed anymore. the additional comments section was blank. Record review showed Resident #1 was not reviewed by the SNR team on 05/27/2020 as scheduled. There no indication any staff reviewed the 05/21/2020 wt of 191 lbs, identified the resident had a significant wt gain of 21 lbs (7.78 %) in less than 30 days. During an interview on 06/23/2020 at 12:50 PM, Staff B explained the weekly SNRs were used for residents with wounds. During the IDT meeting the team would review the resident's nutritional status, assess for improvement / worsening of wounds, and then adjust the plan of care as indicated, to meet the resident's needs. Staff B acknowledged Resident #1 was on weekly SNRs. When asked if Resident #1's 13 lbs wt gain was addressed in the 05/13/2020 or 05/20/2020 SNRs Staff B stated, No and acknowledged it should have been. When asked why a weekly SNR was not performed on 05/27/2020 Staff B indicated it was missed. Failure of facility staff and the IDT Skin and Nutrition Review team, to identify, assess, and address, Resident #1's trendable wt gain, resulted in the resident experiencing a significant wt gain of 21 lbs (7.78%) in less than 30 days without intervention. RESIDENT #3 Resident #3 admitted to the facility on [DATE]. According to the 06/13/2020 Admission MDS, the resident had moderate cognitive impairment, [DIAGNOSES REDACTED]. Review of the June 2020 MAR indicated [REDACTED]. Resident #3's weekly wts were as follows: 06/11/2020, 158 lbs; 06/18/2020, 157.6 lbs; and on 06/25/2020 the weekly wt was signed off, but no wt was recorded. However, review of the facility wt flowsheet showed a wt of 174.2 was input on 06/25/2020, demonstrating a 16 lb wt gain. This wt was struck out as an error on 06/26/2020 by Staff F, Resident Care Manager. According to the wt flowsheet no reweigh was obtained, making it unclear how it was determined the wt was inaccurate. In an interview on 07/30/2020 at 4:53 PM, when asked why the 06/25/2020 wt of 174.2 lbs was struck out Staff F stated, .we thought it was wrong, so (we) tried to get a reweigh. Staff F then acknowledged that a re-weigh was not obtained. When asked how they could determine the wt was inaccurate if they failed to obtain a reweigh Staff F did not respond .Staff A, Administrator then stated, the facility should have obtained the reweigh before striking out the 06/25/2020 wt as inaccurate, but did not. Record review showed a 06/25/2020 provider note, that stated, Resident#3 had No further reports of shortness of breath however (had) occasional oxygen desaturation requiring oxygen via nasal cannula. The resident was also assessed with [REDACTED]. The provider note directed staff to Continue [MEDICATION NAME]. Review of the June 2020 Physicians orders showed the Continue [MEDICATION NAME] order was never implemented. Additionally, a 06/26/2020 at 8:12 PM nurses note by Staff F, stated the resident had [MEDICAL CONDITION] from .the upper tight (thigh) at +2 pitting to the top of the foot +3 pitting. In an interview on 07/30/2020 at 5:03 PM, when asked if the [MEDICAL CONDITION] she documented in her 06/26/2020 nurses note was worse than previously observed Staff F stated, Yes. When asked if there may have been a correlation between the increased [MEDICAL CONDITION] and the 06/25/2020 wt of 174.2, which showed a 16 lb wt gain, Staff F acknowledged it was possible. Review of the June 2020 wt flowsheet showed on 06/29/2020 and 06/30/2020, Resident #3 weighed 181 lbs. Showing a 7 lbs wt gain from the 06/25/2020 wt, that was

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) erroneously struck out as inaccurate and not addressed, and a 23 lb wt gain from the 06/18/2020 wt of 157.6 lbs. Record review showed no indication that staff identified that Resident #3 had a significant wt gain of 14.77% in 11 days, or assessed the resident to determine the root cause. The facility's failure to obtain weekly wts as ordered, and striking out of a wt as an error based on an assumption of inaccuracy, precluded staff from timely identifying Resident #3's significant wt gain, and resulted in a delay of interventions/treatment. REFERENCE: WAC 38-97-1060(3)(h) .

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 Physician's orders (POs) were accurately and timely processed, transcribed, and implemented for two (#1 & 3) of three residents reviewed. The facility's trendable pattern of failed or delayed implementation, inaccurate transcription, and/or failure to follow POs, resulted in significant medication errors, and caused harm to Resident #3. Findings included . Refer to CFR 483.25, F-692, Nutrition/Hydration Status Maintenance, 483.21(b)(3)(i), F-658, Services Provided Meet Professional Standards RESIDENT #3 Resident #3 admitted to the facility on [DATE]. According to the 06/13/2020, Admission Minimum Data Set (MDS, an assessment tool), the resident had moderate cognitive impairment, [DIAGNOSES REDACTED]. According to the facility's 06/06/2020 admission assessment, and provider notes dated 06/08/2020, and 06/12/2020, Resident #3 had no [MEDICAL CONDITION]. A 06//22/2020 provider note indicated Resident #3 was seen due to .Shortness of breath (SOB) .(Resident) reports of shortness of breath which occurred over the weekend .chest x-ray ordered and revealed [MEDICAL CONDITION] congestion . no [MEDICAL CONDITION] .patient started on [MEDICATION NAME] (a diuretic) . The conclusion of the 06/22/2020 chest x-ray, was Modest left basilar (lower) infiltrate (small areas of collection in the lung tissue, due to various causes) and mild congestion. There were no adverse findings to the right upper, mid or lower lobes. Review of the June 2020 PO's showed a 06/11/2020 order to obtain weekly weights (wts), and a 06/22/2020 order to start [MEDICATION NAME] 20 mg (milligrams) daily, for three days for shortness of breath. According to the June 2020 Medication Administration Record [REDACTED]. On 06/25/2020 Resident #3 was re-assessed by the provider who documented No further reports of shortness of breath, however, (had) occasional oxygen desaturation requiring oxygen via nasal canula. The resident was also assessed with [REDACTED]. Subsequently, the provider directed staff to Continue [MEDICATION NAME]. However, record review showed the 06/25/2020 continue [MEDICATION NAME] order was never carried out. During an interview on 07/30/2020 at 4:37 PM, Staff A, Administrator, and Staff F, Resident Care Manager, acknowledged there was a 06/25/2020 order to continue [MEDICATION NAME]. When asked if the order had been carried out and implemented, both Staff A and Staff F stated, No. According to a 06/26/2020 nurses note Resident #3 was now assessed to have left leg [MEDICAL CONDITION] .from the upper (thigh) at +2 pitting to the top of the foot +3 pitting . In an interview on 07/30/2020 at 4:40 PM, when asked if he 2-3+ [MEDICAL CONDITION] to the resident's left leg from foot to thigh was worse than previously assessed Staff A and Staff F stated, yes. On 06/29/2020 Resident #3 was again seen by the provider who assessed .occasional oxygen desaturation, requiring oxygen via nasal canula (and) left leg [MEDICAL CONDITION] . Facility staff were directed to Continue [MEDICATION NAME] and repeat chest x-ray given continued intermittent oxygen desaturation. Record review revealed the resident was on alert for a new [MEDICATION NAME] order, and the facility nurses were documenting daily that Resident #3 had no adverse side effects. Yet no one identified that they had not been administering the [MEDICATION NAME] since 06/24/2020. The 06/29/2020 chest x-ray showed Mild bilateral (both sides) lung base infiltrates and a mild right upper lung infiltrate. There is a small left pleural effusion (fluid in the chest space but outside the lung). A small right pleural effusion cannot be ruled out. The report noted there was .worsening of the right upper lung and right lung base compared to 06/22/2020. The 06/22/2020 chest x-ray showed no adverse findings to the right lung, nor was there a right to left pleural effusion. Review of Resident #3's weekly wts showed the following: 06/11/2020- 158 lbs ; 06/18/2020- 157.6 lbs; 06/25/2020 no wt was recorded; and on 06/29/2020 and 06/30/20 the resident weighed 181 lbs, revealing a 23 lbs wt gain in 11 days. Review of the June 2020 MAR indicated [REDACTED]. Review of the July 2020 MAR indicated [REDACTED]. Additionally, the new order for [MEDICATION NAME] 40 mg twice daily, that was received by 11:35 AM on 07/02/2020, was to start on 07/03/2020 at 6:00 AM. This resulted in the 07/02/2020 afternoon dose of [MEDICATION NAME] 40 mg not being administered. During an interview on 07/31/2020 at 3:16 PM, when asked if there was any indication Resident #3 received the additional dose of [MEDICATION NAME] 20 mg on the morning of 07/02/2020 as ordered, Staff B stated, No. When asked when the [MEDICATION NAME] 40 mg order should have been implemented Staff B indicated Resident #3 should have received 40 mg of [MEDICATION NAME] that evening (07/02/2020). When asked if that occurred Staff B stated, No. A 07/02/2020 8:15 PM nurses note indicated Resident #3 had a unwitnessed fall in his room. Upon assessment it was identified the resident had: right hip pain 10/10 (a pain scale which 10 is the most severe pain and 0 being no pain), but range of motion was intact; an irregular pulse of 149; and a 2.5 inch laceration to the back of his head. The resident was subsequently transported to the emergency room for evaluation. Review of the 07/02/2020 fall investigation showed the facility concluded It is reasonable to believe fall occurred due to acute change in medical status pertaining to the [MEDICAL CONDITION] congestion and weakness. Facility staffs' recurrent failure to carry out, accurately transcribe, and administer Resident #3's [MEDICATION NAME] as ordered, resulted in increased fluid retention, increased LE [MEDICAL CONDITION], significant weight gain, worsening lung/respiratory function (required supplemental oxygen), and ultimately (according to the facility fall investigation) contributed to Resident #3's fall, which resulted in a [MEDICAL CONDITION] and hospitalization . RESIDENT #1 Resident #1 admitted to the facility on [DATE]. According to the 05/15/2020, Quarterly MDS, the resident was assessed with [REDACTED]. This MDS indicated the resident required diuretic medications on all days of the assessment period. Record review showed Resident #1 was followed by Pulse Heart Institute (PHI), a Cardiac Care Clinic. [MEDICATION NAME] (a cardiac medication) According to Physician Orders (POs) dated 02/26/2020, staff were directed to administer [MEDICATION NAME] daily and to hold for (systolic blood pressure less than) 100 or pulse (less than) 60. According to the April and May 2020 Medication Administration Records (MARs), staff assessed the resident with a pulse of less than 60 on 04/02/2020, 04/03/2020, 04/10/2020, 04/11/2020, 04/12/2020, 04/20/2020, 05/09/2020, and 05/29/2020, but administered the medication despite instructions to hold the medication. Administration of cardiac medication outside physician ordered parameters placed this resident at risk for falls and medical complications. During an interview on 06/19/2020 at 12:46 PM, Staff B, Director of Nursing, stated nursing staff should have held the medication as directed and failure to do so constituted a medication error. According to PHI consult documents dated 04/15/2020, staff were directed to, Please decrease to Metroprolol (a cardiac medication) to 12.5 mg once daily. Patient has been bradycardic on last few visits and virtual visit. Review of April 2020 MARS showed that while staff initiated this order on 04/16/2020, nursing staff failed to administer this medication on 04/16/2020. During an interview on 06/19/2020 at 12:46 PM Staff B acknowledged the medication should have been administered on 04/16/2020, but was not. [MEDICATION NAME] (a diuretic) According to PHI consult documents dated and timed 04/15/2020 at 9:49 AM, staff were directed to, Increase [MEDICATION NAME] to 60 mg in the morning and 30 mg in the afternoon. Dosing times are 60 mg PO (orally) [MEDICATION NAME] at (7:00 AM) and 30 mg PO [MEDICATION NAME] at (2:00 PM). Please give the 60 mg PO [MEDICATION NAME] this afternoon at (2:00 PM) then switch to the 60 mg in the morning and 30 mg in the afternoon for the next three days. We will follow up on Friday (04/17/2020) to assess if patient has had weight loss and/or improvement to symptoms at which time we will decide diuretic dose going forward . The PHI consult included directions Take 60 mg in the morning and 30 mg in the afternoon the next three days. Decrease to 40 mg BID (twice a day) unless otherwise directed. Despite receiving the PHI order recommendations at 9:49 AM, according to the April 2020 MAR, nursing staff failed to implement the 60 mg of [MEDICATION NAME] at 2:00 PM as directed on 04/15/2020. According to the MAR, on 04/16/2020, nursing staff administered 60 mg at 3:50 PM, contrary to the PHI directions of 30 mg at 2:00 PM. Record review showed no physician order was obtained to administer 60 mg on the evening 04/16/2020. In an interview on 06/19/2020 at 3:20 PM, when asked why Resident #1 was administered 60 mg of [MEDICATION NAME] on the evening of 04/16/2020, when the order was for 30 mg Staff B explained .because the 60 mg was not administered on the evening of 04/15/2020 as ordered, Staff C, Resident Care Manager, likely scheduled it for 04/16/2020 to make it up. When asked if an order was obtained to do that Staff B stated, No. Review of the April 2020 MAR indicated [REDACTED]. Review of Resident #1's orders showed the resident was to receive [MEDICATION NAME] 60 mg at 7:00 AM and 30 mg at 2:00 PM.

There was no order found to administer an additional 60 mg at 5:28 AM. During an interview on 06/19/2020 at 12:47 PM, when asked why the resident was administered an additional 60 mg of [MEDICATION NAME] at 5:28 AM, Staff B, indicated it resulted from a data entry error. When asked if the resident had an order for [REDACTED]. In an interview on 06/26/2020 at 11:41 AM, Staff B explained that the order on the front page of the 04/15/2020 consult directed staff to administer [MEDICATION NAME] 60 mg at 7:00 AM and 30 mg at 2:00 PM times three days. Thus, the order for [MEDICATION NAME] was completed and the weekend nurses did not have further instructions. When asked to read the instruction on the back of the consult Staff B confirmed

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F 0760 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) that it directed staff to see the end of the after visit summary for complete medication list. The medication list stated, Take 60 mg ([MEDICATION NAME]) in the morning and 30 mg in the afternoon the next three days. Decrease to 40 mg BID unless otherwise directed. Staff B then confirmed facility staff missed those instructions, which subsequently resulted in further medication errors. In an interview 06/19/2020 at 2:55 PM, when asked if the facility had a system by which they audited consults, order input, or the MAR indicated [REDACTED].not unless there is a complaint. REFERENCE: WAC 388-97-1060(3)(k)(ii). .