STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505313	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HALLMARK MANOR	**32300 FIRST AVENUE SOUTH 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 thoroughly investigate one of one medication errors reviewed. Failure to thoroughly investigate this medication error detracted from the facility's ability to identify additional medication errors and provide timely interventions to prevent additional medication errors for one (#1) resident reviewed. Findings included . Resident #1 admitted to the facility on [DATE]. According to the 12/05/2019 Admission Minimum Data Set (MDS, an assessment tool), Resident #1 was identified with multiple complex diagnoses, including Anxiety Disorder and required the use of antianxiety medications on one day during the seven day assessment period. According to Medication Administration Records (MARS) dated 11/27/2019, Resident #1 admitted to the facility with physician orders [REDACTED]. Based on this order, 0.5 mg would be equivalent to 0.25 mls. Review of the label on the [MEDICATION NAME] liquid medication showed directions of, Give 0.3 mls (0.6 mg) by mouth . and did not reflect the POs of 0.5 mg (0.25 mls). According to the November 2019 MAR, staff administered 0.5 mg on 11/28/2019 at 12:00 PM. According to the Narcotic Disposition Record (NDR- a record which shows when, how much, and by whom a medication is dispensed), dated 11/28/2019 at 12:00 PM, staff dispensed 0.3 mls (equivalent to 0.6 mg), following the instructions on the medication bottle, not the physicians orders, which constituted a medication error. Similar findings were identified for 12/01/2019 when nursing staff dispensed 0.3 mls of [MEDICATION NAME] rather than the 0.25 mls ordered by the physician. According to the NDR, staff dispensed 0.3 mls of [MEDICATION NAME] on 11/30/2019. However, review of the MAR indicated [REDACTED]. Similar findings were identified on 12/01/2019 when the NDR reflected [MEDICATION NAME] was dispensed, but the MAR indicated [REDACTED]. According to the facility Investigation log, a medication error was noted for Resident #1 on 12/04/2019. According to the facility investigation, This RN (Registered Nurse) was at the medication cart drawing up resident PRN (as needed) [MEDICATION NAME] liquid .This RN was distracted by DON (Director of Nursing) regarding other job duties. This RN read the medication order wrong and administered 0.5 ml of medication instead of 0.3 ml. Progress notes dated 12/04/2019 showed, .this RN spoke with Dr. (sic) about the medication error and that provider stated the order should of been 0.5 ml all along and not 0.3 ml. Despite the 12/04/2019 note indicating the current POs were incorrect, the order was not changed until 12/06/2019. In an interview on 06/15/2020 at 10:20 AM, when asked why there was a two day delay in changing the [MEDICATION NAME] order, Staff C stated, I don't know and indicated the order should have been changed on 12/04/2019 when the error was identified. According to the NDR, staff again incorrectly dispensed 0.5 mls of [MEDICATION NAME] on 12/05/2019. Again, review of the MAR indicated [REDACTED]. Review of the NDR showed four of four nursing staff dispensed incorrect doses on 11/28/2019, 11/30/2019, 12/01/2019, 12/04/2019 and 12/05/2019. Review of the medication error report showed staff failed to identify: 1. the medication label did not match the physician orders; 2. Staff were following the instructions on the medication label, not the physician orders; 3. incorrect doses were dispensed on five of five occasions; 4. failure of staff to change the physician order [REDACTED]. staff failed to consistently document administration of the [MEDICATION NAME] on the MAR; and 6. what, if any, inservice education was provided to staff. In an interview on 06/15/2020 at 10:20 AM, Staff C indicated the investigation for the 12/04/2019 medication error should have, but did not, identify the errors on 11/28/2019, 11/30/2019, 12/01/2019 and 12/05/2019 and completed additional investigations based on those errors. When asked if the investigation was thorough, Staff C replied the investigation was, missing a couple of things. Staff C elaborated that failure to identify nursing failure to follow physician orders, an opportunity was missed to provide education to nursing staff to prevent recurrence. In an interview on 06/15/2020, when informed the 12/04/2019 medication error investigation was not thorough, Staff A, Executive Director, stated, Agreed. REFERENCE: WAC 388-97-0640(6)(a)(b). .

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.