| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505331 | A. Building<br>B. Wing | 06/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brookfield Health and Rehab of Cascadia | 510 North Parkway<br>Battle Ground, WA 98604 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to report a significant medication error to the State Survey Agency, as required for 1 of 3 residents (Resident 1) reviewed for medication administration and resulted in hospitalization and ventilator support. The failure to report a serious incident delayed appropriate oversight and investigation, placing residents at risk for harm.<br><br>Findings included .<br><br>Resident 1 was admitted to the facility on [DATE] with diagnoses including liver cirrhosis (scarred liver with impaired functioning) and stage 3 kidney disease (impaired functioning of the kidney(s). The Minimum Data Set (MDS) dated [DATE] documented that the resident was unable to participate in the assessment.<br><br>A nursing progress note dated 05/04/25 at 3:08 AM documented:<br><br>[Resident 1] ingested a Zyprexa (antispychotic medication) 10 mg [milligrams] [tablet] that was not ordered for [Resident 1] while standing at my medication cart taking their meds. This nurse notified MD [medical doctor] at approx. 2:00 AM when [Resident 1] began to mumble incoherent speech. MD ordered [Resident 1] to be transferred to ER [emergency room].<br><br>The facility incident log, dated 05/08/2025, noted the incident occurred on 05/03/2025 at 9:30 PM and confirmed that the state hotline was not notified of the event.<br><br>During an interview on 05/21/2025 at 2:30 PM, Staff A, Interim Director of Nursing Services (DNS), stated that Resident 1 ingested 10 mg of Zyprexa, became unresponsive, and was transferred to the hospital, where the resident was placed on a ventilator in the intensive care unit for three days. Staff A reported that regional staff advised the incident did not require reporting, so it was not reported to the state hotline.<br><br>On 06/09/2025 at 1:00 PM, Staff B, newly appointed Interim DNS, stated that the medication error should have been reported to the State Survey Agency.<br><br>On 06/09/2025 at 1:20 PM, Staff C, Chief Executive Officer, was unable to comment on events and stated that he had not been notified of this incident.<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | WAC 388-97-0640 (5)(6)(c)<br><br>. |

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| Brookfield Health and Rehab of Cascadia | 510 North Parkway<br>Battle Ground, WA 98604 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 sampled residents (Resident 1) reviewed for medication errors when another resident's medication(s) were left unattended and then taken by/ingested by the wrong resident. Resident 1 experienced harm when they became unresponsive and required intensive care level hospitalization and mechanical ventilation. This failure placed all residents at risk for medical complications.<br><br>Findings included .<br><br>Resident 1 was admitted to the facility on [DATE] with diagnoses including liver cirrhosis (scarred liver with impaired functioning) and stage 3 kidney disease (impaired functioning of the kidney(s). Resident 1's Minimum Data Set (MDS/an assessment tool), dated [DATE], documented Resident 1 was unable to participate in the assessment.<br><br>A nursing progress note, dated [DATE] at 3:08 AM, documented, Resident 1 ingested a Zyprexa 10 milligram (mg) pill (an antipsychotic medication) that was not his ordered medication while standing at the medication cart and taking their bedtime medications. The writing nurse documented they notified the Medical Doctor (MD) at approximately 2:00 AM when Resident 1 began to mumble incoherent speech. The MD ordered Resident 1 be transferred to the emergency room.<br><br>The Facility Medication Error Report, dated [DATE], documented Resident 1 took medication off the medication cart when the licensed nurse (LN) had stepped away and that the medication was gone when she returned. Resident 1 was sent to and admitted to the hospital. The root cause identified as: cup with roommate's medication in it left on medication cart.<br><br>The Facility Transfer Report, dated [DATE], documented the reason for transfer was due to Resident 1 being unresponsive.<br><br>During an interview on [DATE] at 2:30 PM, Staff A, Interim Director of Nursing Services (DNS), stated that Resident 1 took a 10mg Zyprexa, became unresponsive, was sent to the hospital, and spent 3 days on a ventilator in the intensive care unit. The DNS stated that the LN gave two separate stories to her at different times being that Resident 1 took the medication off of the cart while she was right there and later stated that Resident 1 took the medication while she had stepped away from the cart.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 2:22 PM, Resident 1's daughter stated that the first night after admission, she received a message from a nurse at the facility informing her that Resident 1 was unresponsive and en route to the hospital. The nurse told her, [Resident 1] woke up, hobbled over to her medication cart, grabbed a pill, threw it in their mouth and swallowed it without water. Resident 1's daughter stated she immediately went to the hospital, where Resident 1 was found to be completely unresponsive. Approximately four hours later, Resident 1 was placed on life support, which the resident remained on for several days. Resident 1's daughter stated that Resident 1 was not prescribed Zyprexa, had never been on that type of medication, and she did not believe the resident would have took it on their own. Resident 1's daughter stated, This didn't happen to [Resident 1] because of [their] age, or an injury. This was done to [them]. [Resident 1] survived but could easily have died.<br><br>During an interview on [DATE] at 1:04 PM, Staff D, Licensed Practical Nurse (LPN), stated that to ensure correct medication administration, she checked the medication against the Medication Administration Record (MAR), to verify identity she asks the resident their name. If the resident is nonverbal, she will look at the photo in the residents chart for reference or ask other staff. She stated medications remain secured in the medication cart until ready to administer and were never left unattended on top of the cart.<br><br>During interview on [DATE] at 1:07 PM, Staff E, LPN, stated that she verified the resident's identity by asking the resident to confirm their name, resident chart photos, ID bracelets sometime if they just came from the hospital, or by consulting with familiar staff. She confirmed medications were kept locked in the cart and not left on top of it unattended.<br><br>During interview on [DATE] at 1:12 PM, Staff F, a Registered Nurse (RN), stated that residents were identified by their chart picture or staff verification if non-verbal. She confirmed medications were supposed to be locked in the cart until ready to administer and ensure they were never left unattended.<br><br>During an interview on [DATE] at 1:20 PM, Staff C, Chief Executive Officer, stated he was unable to comment on the incident and had not been notified it had occurred.<br><br>Reference WAC 388-97-1060 (3)(k)(iii)<br><br>. |