STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Health Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 702 North 16th Avenue Yakima, WA 98902	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939 Based on interview and record review, the facility failed to prevent an avoidable accident when COVID 19 reagent solution (a chemical used in a test to determine if a person has COVID 19 [infectious disease by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing that could result in severe impairment or death]) was used as an eye drop for 1 of 1 resident (Resident 2) reviewed for accidents and hazards. This deficient practice placed residents at risk for unnecessary exposure to chemicals and potentially harmful outcomes. Findings included . <Resident 2> Review of the medical record showed Resident 2 admitted to the facility on [DATE] with diagnoses of pelvic fracture, head contusion (a deep bruise caused by a direct blow to the body), and bladder infection. Review of the comprehensive assessment, dated 03/24/2024, showed Resident 2 was cognitively intact and required the assistance of one person for activities of daily living (ADLs). Review of the facility's incident reporting log showed a medication error incident occurred to Resident 2 on 03/23/2024 at 5:00 PM. Review of the facility's incident document, dated 03/23/2024, showed Staff E, Registered Nurse (RN), had Resident 2's prescribed eye drops and a dispensing bottle of COVID 19 reagent solution at Resident 2's bedside. The document showed Staff E noticed they instilled drops of the COVID 19 reagent solution into Resident 2's eye in error when Resident 2 began complaining of a burning sensation. Review of Staff E's witness statement, documented on 03/27/2024, showed they initially took Resident 2's prescribed eye drops to their bedside to administer them. Staff E's statement showed they returned to the medication cart to get other supplies and noticed a similar looking bottle (COVID 19 reagent) on the top of the cart. Staff E stated they mistook the similar looking bottle for Resident 2's prescribed eye drops and took the bottle with them back to Resident 2's bedside. Staff E's statement showed they proceeded to administer Resident 2's eye drops using the incorrect bottle. (continued on next page)

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.

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: 505348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Health Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 702 North 16th Avenue Yakima, WA 98902	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 06/04/2024 at 2:03 PM, Staff F, Consultant Pharmacist, stated that COVID 19 reagent solution was considered a chemical, not a medication, and was not meant to be put in the body. Staff F stated items, such a COVID 19 reagent solution, that were packaged similarly to medications, should not be stored on a medication cart. During an interview, on 06/04/2024 at 3:05 PM, Staff B, Director of Nursing (DON), stated COVID 19 reagent solution should not be stored on the medication cart, and Staff E did not follow the facility's policy for administering medications. Reference: WAC 388-97-1060(3)(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Health Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 702 North 16th Avenue Yakima, WA 98902	

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when physician's orders were not implemented timely for 1 of 2 residents (Resident 1) reviewed for medication administration. This deficient practice placed residents at risk for adverse side effects and an overall decline in medical condition. Findings included . <Resident 1> Review of the medical record showed Resident 1 readmitted to the facility on [DATE] with diagnoses of osteomyelitis (infection in the bone) to the left foot, diabetes mellitus (a disease that a disease that impairs the body's ability to process sugar in the blood), and peripheral vascular disease ([PVD] circulation disorder caused by narrowing, blockage or spasms in the blood vessels of the legs and feet). Review of the comprehensive assessment dated [DATE] showed Resident 1 had moderately impaired cognition, required the assistance of one person for personal cares, hygiene, dressing, and the assistance of two people for transfers and bed mobility. During an interview, on 06/03/2024 at 11:06 AM, a Resident Representative (RR) stated the purpose of Resident 1's admission to the facility was to receive intravenous ([IV] a medical technique that administers medications directly into a person's vein) antibiotic therapy for their osteomyelitis which was managed by an Infectious Disease (ID) physician specialist. The RR stated Resident 1 had around the clock care at home and would be returning home once the IV antibiotic therapy was completed. Review of the Medication Administration Record (MAR) for May 2024 showed Resident 1 admitted to the facility with orders for Ampicillin-Sulbactam ([brand name Unasyn] an antibiotic medication used to kill the infection causing bacteria)-three grams ([g] a unit of measure) IV every six hours for 15 days. The MAR showed the administration times were 5:00 AM, 11:00 AM, 5:00 PM, and 11:00 PM, and the last dose was administered on 05/26/2024 at 5:00 AM. Review of the medical record showed Resident 1 was seen by the ID specialist, on 05/22/2024 at 1:40 PM, and returned with a visit summary that gave orders to continue IV Unasyn for 3 more weeks. Further review of the visit summary document showed it had been signed by Staff C, Charge Nurse. During an interview, on 06/04/2024 at 12:26 PM, Staff C stated the Charge Nurse job duties included processing physician orders, coordinating care with outside providers, discharge preparations, and participating in care conferences. Staff C stated they were the Charge Nurse on 05/22/2024 and their signature was on Resident 1's visit summary document to indicate that they had reviewed the document. Staff C stated they recalled briefly reviewing the visit summary document but missed the directions to continue Resident 1's IV antibiotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Health Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 702 North 16th Avenue Yakima, WA 98902	

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 06/04/2024 at 2:43 PM, Staff D, Resident Care Manager (RCM) stated they were working as the Charge Nurse on 05/28/2024 and was following up on the status of Resident 1's IV access site. Staff D stated it was at that time they discovered that Resident 1's IV antibiotics had discontinued, on 05/26/2024 after the 5:00 AM dose was administered, despite orders to continue for three more weeks. Staff D stated they notified Staff B, Director of Nursing, right away. Review of the facility's incident reporting log showed an incident of other nature occurred to Resident 1 on 05/28/2024 at 9:30 AM. The incident log entry showed Resident 1 sustained no injuries from the incident and it was not reported to the State Agency. Review of the facility's incident investigation, dated 05/28/2024, showed the continuation order for Resident 1's IV antibiotics was not processed and placed on the MAR resulting in medication errors. The investigation summary showed Resident 1 had missed a total of seven doses of IV antibiotics, equaling seven medication errors. During an interview, on 06/04/2024 at 2:03 PM, Staff F, Consultant Pharmacist, stated in treating a serious infection, such as osteomyelitis, it was important to maintain regular levels of the antibiotic in the body. Staff F stated this was done by administering the antibiotic medication at timed intervals, and even one missed dose could impact a resident's medical condition. Staff F stated that seven missed antibiotic doses for the treatment of Resident 1's osteomyelitis was a significant medication error. During an interview, on 06/04/2024 at 3:05 PM, Staff B stated they recognized the incident for Resident 1 on 05/28/2024 as a medication error, but did not feel it rose to the level of being a significant medication error. Reference: WAC 388-97-1060(3)(k)(iii)