STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Baker Care Center	2905 Connelly Avenue Bellingham, WA 98225

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** 36841 Based on interview, and record review, the facility failed to ensure they were free of significant medication errors for 1 of 3 sampled residents (Resident 1). The facility administered two doses of an antibiotic listed on Resident 1's allergy list. This failure placed Resident 1 at an increased risk of an allergic reaction to the medication, potential complications, and placed other residents at risk of medication errors. Findings included . Resident 1 admitted to the facility on [DATE] with diagnoses to include heart failure. Review of Resident 1's clinical record showed allergies listed as nitrofurantoin (antibiotic) and sulfa (antibiotic). Review of Resident 1's hospital discharge record, dated 09/07/2024, showed the resident had a history of urinary tract infections (UTIs) and had allergy to nitrofurantoin and sulfa antibiotics. Review of urine culture results, dated 09/28/2023, showed Resident 1 had an UTI. There was a handwritten order on the urine culture result form for Septra DS (sulfa antibiotic) twice daily for seven days was signed by the resident's provider. Review of Resident 1's Medication Administration Record (MAR) for September 2023, showed the resident received Bactrim DS (same medication as Septra DS) on the evening of 09/28/2023 and the morning of 09/29/2023. The MAR showed the resident had an allergy to nitrofurantoin and sulfa antibiotics. Review of nursing progress note dated 09/28/2023 showed Resident 1 received their first dose of Bactrim DS. Review of Advanced Registered Nurse Practitioner (ARNP) note, dated 09/29/2023, showed they received notification from a nurse, that the pharmacy had contacted the facility and informed them Resident 1 was allergic to sulfa antibiotics. The ARNP discontinued the Septra DS and started a different antibiotic. Review of progress note showed Resident 1 had a light rash on arms and oral discomfort; unknown if related to one of the antibiotics. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of electronic-mail communication from the pharmacy, showed Resident 1's allergy to sulfa medications was listed and it flagged when the order for the sulfa antibiotic was processed on 09/28/2023. The pharmacy reported they faxed the facility about the allergy. Due to lack of documentation and the length of time since the event, the pharmacy staff were unsure what happened; however, the medication was sent to the facility that evening. In an interview on 04/01/2024 at 4:10 PM, Staff A, Registered Nurse (RN)/Director of Nursing Services, stated nurses were to follow the eight rights when administering medications and were not to administer medications on the resident's allergy list without special consent. On 04/02/2024 at 10:35 AM, Staff B, RN, stated when orders were received for a resident, they routinely checked for allergies. Staff B stated the nurses completed the final check for allergies to medications prior to administration. On 04/02/2024 at 1:15 PM, Staff C, RN/Resident Care Manager, stated they recalled Resident 1 had an allergy to sulfa antibiotics. Staff D stated the resident received two doses and then the pharmacy informed the facility of the allergy. Staff C stated the resident's allergy to sulfa medications was listed in the resident's clinical record. On 04/03/2024 at 2:30 PM, Staff A stated it was their expectation nurses would check for allergies when orders were processed and administered. They stated they did not have a specific policy, but it was a standard of practice. Staff A stated they did not have additional information providing a justified reason the sulfa medication was administered to Resident 1 in spite of their allergy. Refer to WAC: 388-97-1060(3)(k)(iii)