STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER: Royal Park Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7411 North Nevada Spokane, WA 99208	

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 27590 Based on interview and record review, the facility failed to provide the necessary care and services to maintain the resident's highest practicable level of well-being for 1 of 3 residents (Resident 1) reviewed for diabetes management. Resident 1 experienced harm when they were found unresponsive from a blood sugar of 39 milligrams (mg)/deciliter (dl) (a normal blood sugar ranges from 80 mg/dl to 130 mg/dl) and Staff administered an oral glucose gel which resulted in Resident 1 aspiration (when food or drink goes into the lung). This failure placed other residents at risk for diminished quality of care. Findings included . Review of the facility assessment, dated 10/28/2024, showed Resident 1 had diagnoses to include diabetes and lung disease. Resident 1 had some difficulty making their needs known. Per the assessment, the resident took insulin (a hormone that helps regulate blood sugar levels) to manage their diabetes. Resident 1 was set up assist for self-care which included eating. Review of a facility policy titled Hypoglycemia [low blood sugar]/Hyperglycemia [high blood sugar] recommended Guidelines, dated May 2016, showed the recommended guidelines for a resident whose blood sugar was below 80 mg/dl, and able to swallow, a nurse was to give the resident food such as fruit juice, crackers, or glucose gel (sugar in gel form). The blood sugar was to be re-checked 15 minutes later. If the resident was unable to swallow, the nurse was to give an injection of Glucagon (a hormone produced by the pancreas that stimulates the liver to release glucose into the bloodstream) and re-check the blood sugar after 15 minutes. This was to be repeated if the blood sugar remained low. Review of the resident's care plan, dated 09/30/2024, showed the resident had diabetes. The resident was to get medication as ordered by the doctor and staff were to monitor and document side effects and effectiveness. Review of Resident 1's Medication Administration Record (MAR) for October 2024, showed the resident received an oral medication twice a day for diabetes, and was to be given 9 units of Insulin Lispro (a fast-acting insulin that starts to work about 15 minutes after injection) with meals and 18 units of Lantus (a long-acting insulin) at bedtime. Blood sugars were ordered to be checked three times a day. On 10/08/2024 at 12:00 PM, it was documented the resident's blood sugar read 189 mg/dl and Resident 1 received 9 units of insulin. (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of nurse progress notes, dated 10/08/2024, showed Staff A, Licensed Practical Nurse (LPN), went into Resident 1's room around 1:10 PM, after it was reported Resident 1 was unresponsive. Staff A documented the resident's first blood sugar was 39 mg/dl and Staff A gave a shot of Glucagon. The second blood sugar taken was 31 mg/dl and Staff A documented they gave a tube of fast acting glucose gel. There was no documentation to show the resident was no longer unresponsive. The next blood sugar was at 1:24 PM and had dropped to 26. Emergency medical personnel (EMS) arrived at the facility and transported the resident to the hospital. On 11/06/2024 at 11:35 AM, during a confidential interview, staff in Resident 1's room were heard yelling to the resident you have to swallow, you have to swallow. On 11/06/24 at 2:40 PM, Staff B, LPN, stated they had worked the morning of Resident 1's incident. Staff B took Resident 1's blood sugar at lunch, which read 189 mg/dl. The resident was then given the 9 unit of insulin, as ordered. Staff B stated the lunch trays were already on the unit and staff had started to deliver them. Staff B was in another room charting when they heard someone yell for help and said Resident 1 was unresponsive. Staff B entered Resident 1's room and Staff A had already arrived in the room. Staff B watched Staff A give the resident a shot of Glucagon. Staff B went on to say Staff A then opened a tube of glucose gel and asked Staff B to give it to the resident. Staff B told Staff A the resident was not responsive and refused to give it. Then Staff A had Staff C, Certified Nursing Assistant (NAC), massage Resident 1's throat as Staff A attempted to give Resident 1 the glucose gel. Staff B observed several empty tubes of the glucose gel next to the resident. After the EMS came, the resident continued with a low blood sugar. The EMS were told the resident was given tubes of glucose gel; they told staff to stop giving the oral gel, and asked for a suction machine. The resident was then transported to the hospital. On 11/13/2024 at 10:40 AM, Staff D, Director of Nursing (DNS), stated there was not a medication error for Resident 1 because the correct dose of insulin, 9 units, had been given to the resident. Staff A stated the resident was on a sliding scale (the amount of insulin given was based on the blood sugar reading) which was changed by the physician to administer 9 units of insulin with meals. Staff D stated Resident 1 had received a lunch tray after the insulin had been administered. When asked if an unresponsive resident should receive glucose gel by mouth, Staff D stated the resident should not receive anything by mouth. Staff D also confirmed if a resident was drowsy and unable to respond to direction, they should not receive anything by mouth. Saff D stated they had received statements from the staff that cared for Resident 1 but no investigation had been done. Review of staff statements about the incident with Resident 1 showed Staff A reported they had given Resident 1 a Glucagon shot because the blood sugar was 39 mg/dl. Staff A stated the resident's blood sugar kept dropping and they gave a tube of glucose. Staff A wrote the resident was swallowing and waking up. Staff B's statement reported Staff A gave a shot of Glucagon. Staff A told Staff B to give the resident glucose gel, and they refused since the resident was still unresponsive. Staff B observed Staff A put glucose gel in Resident 1's mouth and Staff C rubbed the resident's throat. Staff B stated Staff yelled to the resident to swallow, swallow. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Staff C reported they had set up Resident 1's lunch tray. At about 1:10 PM another staff member asked if the resident was normally hard to wake up. Staff C went into the resident's room, and they were up in a wheelchair limp and clammy. Staff C stated Staff A arrived, took a blood sugar which was 39 mg/dl and gave a shot to the resident. Staff A then put some pink stuff in the resident's mouth. Staff C massaged the side of the resident's neck to help them swallow. Staff A then repeated the shot and put more pink stuff in the resident's mouth because the next blood sugar read 31 mg/dl. On 11/08/2024 hospital records were reviewed and showed EMS reported to the emergency room (ER) they arrived at the facility and witnessed staff give glucose gel to an unresponsive resident. The EMS instructed staff to stop giving it, asked for a suction machine, and suctioned the resident's airway. The resident was noted to have gurgling sounds while breathing. A note from the ER nurse documented the resident was unresponsive when EMS arrived at the facility. The resident had been given glucose by mouth and was suspected to have aspirated because their oxygen saturation (the measure of how much oxygen is traveling through your body) was low and the resident had raspy lung sounds. The record showed Resident 1 was diagnosed with aspiration pneumonia. Reference: WAC 388-97-1060(1)