STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505436	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gig Harbor Health and Rehabilitation	3309 45th Street Court Northwest Gig Harbor, WA 98335

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on observation, interview and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice when 3 of 3 residents' (Residents 1, 2, 3) physician recommendations or orders were not carried out timely, assessment and monitoring of wounds and changes in condition were not done, and coordination of care with providers was incomplete. These failures placed residents at risk for harm from worsening or potential infections and wounds and placed residents at risk for unmet care needs and diminished quality of life. Findings included . < Resident 1 > Resident 1 was admitted [DATE] with diagnoses including heart failure, osteomyelitis (bone infection) and an infection that developed after a coronary artery bypass graft (surgery to help restore blood supply to the heart) in the surgical wound site at the sternum (breastbone). Admission Orders, dated 01/29/2024, documented Resident 1 was to receive 39 days of intravenous (IV) Zosyn (antibiotic) three times daily to treat the infection of the sternum. February 2024 Medication Administration Record (MAR) showed Resident 1's IV Zosyn was not documented as administered on 02/03/2024 (2:00 PM), 02/14/2024 (2:00 PM and 10:00 PM), 02/16/2024 (6:00 AM) and 02/17/2024 (6:00AM). Nursing Progress Note, dated 02/28/2024 at 7:04 AM, documented Resident 1 reported chest tightness on the previous evening when receiving the IV Zosyn so refused the morning IV administration. No assessment of chest tightness or notification to the physician was documented on 02/28/2024 and the reported reaction was not documented the previous day, on 02/27/2024. No alert charting to monitor for possible adverse reaction to medication was found. Nursing Progress Notes, dated 02/28/2024 at 9:21 PM, documented Resident 1 refused the IV Zosyn, the running was stopped and the nurse practitioner was notified and following up with infectious disease provider. Nursing Progress Notes, dated 02/29/2024, documented Resident 1 continued to refuse the IV Zosyn and reported that the medication was refused because it caused tightness in the chest and throat. The Progress Note documented MD aware. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The March 2024 MAR documented that Resident 1 continued to refuse IV Zosyn three times on 03/01/2024 and once on 03/02/2024. No notes were found that showed provider notification of continued refusals of IV Zosyn by Resident 1. At 5:12 AM on 03/03/2024, Nursing Progress Notes showed Resident 1 was nauseated, had low blood pressure and heart rate and the nurse practitioner was informed and ordered anti-nausea medication. The Nursing Progress Note did not document notification to the provider that Resident 1 was not receiving ordered antibiotic therapy and there were no new orders from infectious disease physician. On 03/03/2024 at 7:47 AM, Nursing Progress Note documented Resident 1 was lethargic and groggy with low blood pressure and low oxygen saturation. The Nursing Progress Note documented Resident 1 was vomiting and had a red rash on both palms, arms and leg and was transferred to the hospital. Hospital Physician Progress Note, dated 03/07/2024, documented that Resident 1 was admitted to the hospital intensive care unit on 03/03/2024 in septic shock (life-threatening condition caused by severe infection) as a result of incomplete antibiotic therapy for the resident's sternal wound infection and osteomyelitis (bone infection). The Hospital Physician Progress Note showed Resident 1 was also treated for a systemic rash. Facility Incident Investigation, dated 03/05/2024 showed a faxed order from the infectious disease physician, dated 03/01/2024, for a new antibiotic to replace the IV Zosyn. Review of the faxed order showed it was printed out by the facility's non-clinical staff on 03/01/2024 at 1:45 PM. Resident 1's medical record did not show that these orders were noted, transcribed or carried out by nursing staff. Nursing Progress Notes did not show that nurses placed Resident 1 on alert monitoring and did not document attempts to contact the infectious disease physician for new orders or notify the resident's physician or nurse practitioner that the IV Zosyn was not being administered. On 04/16/2024 at 6:41 PM, when asked if there was a system in place to monitor the MAR for administration of IV medication, Staff B, Director of Nursing Services, said, I don't know that we had a process to review it; it wasnt being audited then. During an interview on 04/17/2024 at 9:44 AM, Staff C, Nurse Practitioner, indicated the nurse and Resident Care Manager (RCM) were instructed on 02/28/2024 to follow up with the infectious disease provider to obtain new orders for Resident 1's antibiotic therapy. Staff C stated that after 02/28/2024, nursing staff did not report that they were still awaiting new orders from the infectious disease provider. Staff C stated there was no notification from nursing staff that Resident 1 complained of tightness in chest and throat. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:39 PM, on 04/17/2024, Staff B said that the MAR should have been audited and omissions of IV Zozyn followed up upon. Staff B said that when Resident 1 refused the IV Zosyn and reported a reaction, the nurse should have assessed reported reactions, held medication, notified provider and placed the resident on alert charting to monitor for adverse reactions. Staff B said the RCM should have contacted the infectious disease provider to obtain new orders for Resident 1 or to follow up if there were no new orders forthcoming. Staff B stated that if there was a delay in obtaining new orders, Resident 1's physician should have been notified for coordination of care between nurse and providers. Staff B stated that better communication and coordination with Resident 1's outpatient wound clinic would have resulted in more timely notification that the culture and sensitivy (test to see which antibiotic works best for the illness) done on 02/21/2024 showed IV Zosyn was not effective in the treatment of Resident 1's infection. <Resident 2> Review of facility policy titled, Non-Pressure Injury/Ulcer Management,, un-dated, showed weekly skin observations would be conducted by a licensed nurse and finding would be documented in the resident's medical record. Treatments and interventions would be ordered by the provider which included wound dressings. Resident centered interventions and treatments would be prescribed by the provider and administration of the treatments would be documented in the resident's medical record. The provider would be notified of the resident's refusal of prescribed treatment and/or interventions for prevention and care. A resident centered care plan would be developed and implemented to address the resident's wound including interventions to promote healing and minimize worsening. Resident 2 was admitted to the facility on [DATE] with diagnoses that included surgical repair of multiple broken bones in the left leg, above and below the knee. Resident 2's admission Minimum Data set (MDS), an assessment tool, dated 02/23/2024, showed Resident 2 had a surgical wound but no surgical wound care or application of non-surgical dressings. The MDS showed Resident 2 did not have behaviors and did not reject care. Review of surgical wound care plan, dated 04/08/2024, showed Resident 2 had a surgical wound to the left leg and required the dressing to be monitored per orders to ensure it was intact and adhering. Staff were to notify the nurse if the dressing was loose. Staff were to monitor/document/report to the provider any changes in skin status including wound healing, signs/symptoms of infection and wound size. Review of February 2024, March 2024, April 2024 Medication Administration Records and Treatment Administration Records did not show monitoring of the surgical wound or wound care was ordered or completed. Review of Hospital Discharge Orders, dated 02/20/2024, showed Resident 2 was allergic to adhesive, adhesive tape tears skin off. Wound care was ordered routine per facility protocol AND/OR please see attached wound care notes; for left leg operative area. No additional wound care notes were attached. Review of Admission Progress Note, dated 02/21/2024 at 01:01 AM, showed Resident 2 admitted to the facility with an ACE wrapped surgical wound under a metal brace. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Nursing Progress Note, dated 02/21/2024 at 15:13, showed a weekly skin check was documented. The surgical wound was described as covered with an ACE bandage and metal hinged brace. No description of the wound was included. Review of progress notes showed a lack of documentation for surgical incision care/wound dressings or refusal of staff assessment/care from admission to discharge to hospital on 03/31/2024 except on 03/03/2024, 03/20/2024, and 03/29/2024 where staff noted during a weekly skin assessment, Resident 2 refused staff assessment of the leg incision. The ACE wrap and metal hinge brace were noted to be in place. On 04/16/2024 at 5:00 PM, Resident 2 said that during the first post surgery follow up visit, the original dressing was still on the left leg, 7 weeks later. Resident 2 said there was tape over the top of the incision and was fusing with the skin because of being allergic to it. Resident 2 said the steri-strips (topical suture dressing) were still stuck in the skin and the provider said to just leave it be. Resident 2 would not let the facility staff touch it. On 04/17/2024 at 1:06 PM, Staff B said the facility would follow admission orders on what kind of care to provide for surgical wounds. Staff B said dressing changes and wound care should have been completed daily. When asked what should happen if there were no orders for a new surgical wound, Staff B said talk with the provider to get orders for wound care. When asked about the situatuion with Resident 2, Staff B said it should have been care planned, documented, and staff should have reached out to the suregon to see what to do. Staff B reviewed Resident 2's progress notes and said a wound care entry was not found. Staff B said staff should have discussed with Resident 2 to determine the resistance to wound care and offer reassurance. Staff B said they should have made and discussed the plan with Resident 2. Staff B said the nurses should have come to the management when Resident 2 refused wound care. < Resident 3 > Resident 3 was readmitted [DATE] with diagnoses including bi-polar disorder (mood swings including mania and depression that affect thinking, judgement, energy, sleep and behavior). Psychiatric Progress Note, dated 03/04/2024, documented Resident 3 appeared to be having a manic episode and recommended lab work including a urinalysis (UA) to test for infection. No orders were found for the lab work recommended by the psychiatrist for Resident 3 and no notes explaining why these recommendations were not accepted were found. No notes indicating Resident 3's primary care provider was notified that lab work was recommended by the psychiatrist. Nursing Progress Notes, dated 03/31/2024, documented Resident 3 had increased behaviors including flight of ideas and delusions about staff wanting to poison resident. Physician Order, dated 04/03/2024 at 10:51 AM, requested urinalysis (UA) to evaluate Resident 3 for possible urinary tract infection (UTI). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/04/2024 at 10:46 AM, Collateral Contact 1 indicated that mental health providers had attempted to coordinate care with facility interdisciplinary team. CC stated that offers to attend care conferences did not result in invitations. CC stated that the mental health providers were concerned that Resident 3's UTIs were being overlooked because the resident's usual signs and symptoms of infection included increase in psychiatric symptoms. On 04/04/2024 at 1:38 PM, Resident 3 was observed in bed, eating yoghurt and speaking rapidly, shifting from topic to topic. When asked what the signs and symptoms of UTI were, Resident 3 said, it is slide into manic side. At 2:37 PM, Staff E, Registered Nurse, stated they did not know there was an order placed the day before and had not been carried out. Staff E said the order for Resident 3's UA should have been carried out the same day. Staff E indicated normally the provider would tell staff about an order, the specimen would be collected and the lab would be called for pick up of specimen. Staff E said that it was over 24 hours since the UA order for Resident 3 was written. Staff E said the UA order did not get transferred to Resident 3's Medication Administration Record (MAR) so nurses did not see that it was there. On 04/16/2024 at 6:41 PM, Staff B, Director of Nursing Services, indicated the expectation was that nurses should have completed the order the same day it was given. Staff B indicated if a consulting provider made a recommendation it should be clarified with the primary care provider who would have to option to accept the recommendation.