

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/13/2025
NAME OF PROVIDER OR SUPPLIER  Gig Harbor Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46827</b></p> <p>Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when medications were not administered in accordance with provider orders for 1 of 8 sample residents (Resident 1) reviewed for medication errors. This placed residents at risk for adverse medical conditions, changes in health conditions, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the policy titled 'Medication Orders', undated, notes under the subtitle Recording Orders . 2. Medication Orders-When recording orders for medication, specify the type, route, dosage, frequency, and strength of the medication ordered .</p> <p>Review of the policy titled 'Medication and Treatment Orders', dated 10/01/2021, notes under the subtitle Specific Procedures / Guidance . 7. Verbal orders must be recorded immediately in the resident's medical record by the person receiving the order and must include prescriber's last name, credentials, the date, and the time of the order . 9. Orders for medications must include:</p> <ul style="list-style-type: none"> <li>a. name and strength of the drug:</li> <li>b. number of doses, start and stop date, and/or specific duration of therapy:</li> <li>c. dosage and frequency of administration:</li> <li>d. route of administration;</li> <li>e. clinical condition or symptoms for which the medication is prescribed; and</li> <li>f. any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.).</li> </ul> <p>Resident 1 was admitted to the facility on [DATE] with multiple diagnoses. The quarterly Minimum Data Set (MDS, an assessment tool), dated 03/24/2025, showed Resident 1 was moderately cognitively impaired.</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/03/2025 at 2:33 PM, Staff B, Registered Nurse (RN), said she was assigned to Resident 1, during the NOC shift (10 PM - 6 AM) on 04/29/2025, and observed Ceftriaxone (an antibiotic) 2 gram (gm) / Dextrose (a soluble sugar found in the bloodstream) 50 milliliter (ml) being administered via the clysis system (used for the intravenous or subcutaneous introduction of fluids into the body).</p> <p>Review of Resident 1s April 2025 Medication Administration Record (eMAR) and Treatment Administration Record (eTAR) (a comprehensive record of physicians' orders) showed no antibiotic ordered.</p> <p>Facility investigation, dated 04/29/2025, documented the provider gave verbal orders for Rocephin 1 gm IM (intramuscular) 1 dose, 2 liters of Normal Saline (hydration) via the clysis system, urinalysis with culture and sensitivity, a complete blood count, a comprehensive metabolic panel and a chest x-ray to rule out infection. The investigation documented the Licensed Nurse failed to:</p> <ol style="list-style-type: none"> <li>1. Enter orders into Point Click Care (the medication administration system)</li> <li>2. Administered Rocephin 1 gm IM</li> <li>3. Complete the form used for changes in condition and place the resident on alert charting</li> <li>4. Lastly Licensed nurse used another resident's medication</li> </ol> <p>On 05/13/2024 at 12:50 PM, Staff A, Director of Nursing Services (DNS) / Registered Nurse (RN), said the expectation was for the nurse to recite back verbal orders received and input them into Point Click Care. Staff A said usually the providers input their own orders but in this case the provider was not able to because of a missing National Provider Identifier (NPI, a unique 10-digit identification number for healthcare providers). Staff A said an audit was completed and any missing NPIs have been added so this should no longer be a problem. Staff A said it is not acceptable that someone else's medication was used for this resident. Staff A said the medication was no longer in use and was awaiting return to the pharmacy. Staff A said the expectation was for the nurse to administer the medications as ordered by the provider and to pull medication from the Pyxis machine (an automated medication dispensing system). Staff A said the nurse should have called the provider for clarification before administering the medication.</p> <p>Reference WAC 388-97-1260 (3)(k)(iii)</p>		