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	06/05/2026

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent significant medication errors by administering medications to the wrong resident for 1 of 3 residents (Resident 1) reviewed for medication errors. Resident 1 experienced harm when they were transferred to the hospital for a life-threatening medication overdose requiring life support. This failure placed residents at risk for negative side effects of medications, hospitalization, and a diminished quality of life. Findings included.Review of the Lippincott Nursing Procedures 8th edition safe medication administration showed, To promote a culture of safety and to prevent medication errors, nurses must avoid distractions and interruptions when preparing and administering medications and adhere to the five rights of medication administration: identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route.RESIDENT 1Resident 1 admitted to the facility on [DATE] with multiple diagnoses. The discharge minimum data set (MDS), an assessment tool, dated 05/19/2026, showed Resident 1 was moderately cognitively impaired.RESIDENT 2Resident 2 admitted to the facility on [DATE] with multiple diagnoses. The admission MDS, dated [DATE], showed Resident 2 was moderately cognitively impaired.Review of the progress note dated 05/19/2026 at 9:00 PM showed a nurse was training a new orientee and medications for Resident 2 were given to Resident 1. The medications given were Seroquel (an antipsychotic medication) 400 mg, Zoloft (a medication given for depression) 200 mg, and Tegretol (a medication given to prevent seizures) 200 mg. Review of the progress notes showed the error was identified immediately, the resident was assessed with no negative effects, and the physician was notified. Review of the progress notes showed Resident 1 was sent to the emergency department (ED) for evaluation. Review of the provider order dated 04/28/2026 showed Resident 1 received Seroquel 12.5 mg twice daily. Review of the orders showed Resident 1 did not take Zoloft or Tegretol.Review of the hospital Discharge summary dated [DATE] showed Resident 1 arrived in the ED on 05/19/2026. Review showed Resident 1 was initially sleepy and following commands. Review showed Resident 1 quickly went into severe distributive shock (a condition where the body's blood vessels lose their ability to constrict properly) and was administered Narcan without success. Review of the document showed Resident 1 had to be intubated (a breathing tube that is inserted into the windpipe when unable to breathe on your own) and admitted to the Intensive Care Unit (ICU). Review showed Resident 1 developed pulmonary edema (a serious condition where excess fluid accumulates in the lungs, leading to difficulty in breathing and inadequate oxygen supply to the body) and distributive shock secondary to a medication overdose. Review of a document titled notice of disciplinary action dated 05/26/2026 showed during orientation Staff C, Licensed Practical Nurse (LPN), administered medications to the wrong resident resulting in harm. Review of the documentation showed the five rights of medication were not followed. Review of a document titled notice of disciplinary action dated 05/26/2026 showed Staff D was orienting Staff C and left them unsupervised during medication administration. Review showed Staff C administered the medication to the wrong patient resulting in harm. Review of the document showed orientees were not to be left alone during medication administration until (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 0760 Level of Harm - Actual harm Residents Affected - Few	competency was validated. Review showed the five rights of safe medication administration were not followed and did not meet the expectations of the facility. During an interview on 05/29/2026 at 1:07 PM, Resident 2 said Staff C, LPN, came into the room and went to Resident 1 to administer medications. Resident 2 said Resident 1 asked Staff C why there were so many pills. Resident 2 said Staff C administered the medications to Resident 1 and then Resident 1 was quickly taken away by an ambulance. During an interview on 06/05/2026 at 12:16 PM, Staff C, LPN, said the day the medication error occurred was their second day working in the facility and their first day working on that hall. Staff C said this was their first job in long term care and they were a new nurse. Staff C said Staff D, LPN, the nurse training them, set up the medications and handed the prepared medications to them to administer to the resident. Staff C said they asked Resident 1 if their name was Resident 2's name. Staff C said Resident 1 said yes. Staff C said the picture on the electronic medication administration record (EMAR) was old and not accurate. Staff C said Staff D was outside the room preparing medications for another resident when they were administering the medications to Resident 1 and was not in the room with them. During an interview on 06/05/2026 at 12:22 PM, Staff E, LPN, said the five rights of medication administration are the right patient, right time, right dose, right route, and right medications. Staff E said these rights should be completed for every medication pass. Staff E said if a medication error is identified, they would check for allergies, notify the provider, and monitor based off of the provider orders. During an interview on 06/05/2026 at 12:28 PM, Staff F, Registered Nurse (RN), said the five rights of medication administration are right dose, right medication, right patient, right time, and right route. Staff F said the five rights should be done every time a medication is administered. Staff F said if a medication error was identified, they would assess the patient, compare what was given to the orders, report it to the provider, call 911 if it was an emergency, notify management, and document the event. During an interview on 06/05/2026 at 12:45 PM, Staff B, Registered Nurse/Director of Nursing Services (RN/DNS) said Staff D was training Staff C, set up the medications for Resident 2, then gave them to Staff C to administer. Staff B said Staff D went to get water, when they returned to the medication cart, and saw Staff C administering the medications to Resident 1. Staff B said when the error was identified there was an immediate assessment of Resident 1 completed, the provider was notified, and Resident 1 was sent to the ED. Staff B said Resident 1 was intubated when they got to the hospital. Staff B said the resident left the hospital and went to a memory care unit instead of returning to the facility. Staff B said there was not a structured training program for new nurses prior to the medication error, but as a result one was put in place to prevent further errors. Staff B said Staff C should not have administered medications they did not prepare. Reference WAC 388-97-1060(3)(k)(iii)