STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505526	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of South Hill	2508 7th St Southeast Puyallup, WA 98374

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** 40817 Based on interview and record review, the facility failed to provide an ordered medication, significant to the health of the resident, for 1 of 6 sampled residents (Resident 27) reviewed for medication administration. Resident 27 experienced harm when they developed stroke like symptoms and was emergently transferred to the hospital for a change in condition. The facility has corrected the above deficiency prior to the standard survey and constituted as past non-compliance (the facility was not in compliance at the time the incident occurred; however there was sufficient evidence the facility corrected the non-compliance after it was identified) and is no longer outstanding. Findings included . Review of Lippincott Manual of Nursing Practice, Eighth Ed., 2006, showed an anticoagulant (blood thinning) medication can be used to disrupt the blood's natural clotting function, when there is a risk of blood clots forming. Such a risk is present with a diagnosis of atrial fibrillation (A-fib, an abnormal heart rhythm). Review of a facility policy titled, Medication Reconciliation across the Continuum of Care, reviewed 09/05/2024, showed .hospital transfer form (if coming from the hospital) are received by the licensed nurse who reconciles the medication list, phones the physician if necessary for clarification, obtains physician orders, and then updates the electronic health record. Review of the electronic health record (EHR) showed Resident 27 admitted to the facility on [DATE] and discharged on [DATE]. Resident 27 admitted with diagnoses of atrial fibrillation, encounter for orthopedic aftercare following surgical amputation (post-surgery care of removed limb), and peripheral vascular disease (a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, spasm, or become blocked). Review of hospital discharge orders showed Resident 27 was to continue taking an anticoagulant (blood thinning) medication. Review of the provider's orders from 10/10/2024 through 10/21/2024 showed Resident 27 did not receive an order for an anticoagulant. (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	Review of a progress note, dated 10/21/2024, showed Resident 27 experienced face drooping, left-sided weakness, and left eye dilation (increase in size) and was transported to the hospital. Review showed the hospital emergency department called the facility several times requesting information about an anticoagulant including that the resident was supposed to be receiving one. It was discovered Resident 27 had not received the hospital ordered anticoagulant medication while at the facility. Review of the investigative report regarding Resident 27's lack of anticoagulant medication, dated 10/25/2024, showed the facility failed to transcribe the anticoagulant medication into the resident's EHR and Resident 27 had not received the anticoagulant medication while at the facility. Review showed this was considered a medication error. During an interview on 10/30/2024 at 12:16 PM, Staff A, Administrator, stated Resident 27 had not received the anticoagulant medication as it was not transcribed into the resident's EHR. During an interview on 10/30/2024 at 12:16 PM, Staff S, Regional Nurse, stated Resident 27's emergent transfer to the hospital could potentially have been caused by the lack of anticoagulant medication. During an interview on 10/31/2024 at 9:53 AM, Staff B, Director of Nursing Services, stated Resident 27's lack of anticoagulant medication was a significant medication error and a contributing factor in their transfer to the hospital. During an interview on 10/31/2024 at 9:55 AM, Staff A, Administrator, stated Resident 27's lack of anticoagulant medication was a significant medication error and a contributing factor in their transfer to the hospital. During an interview on 10/31/2024 at 1:25 PM, Staff A, Administrator, stated after the incident was reported to them they immediately began working on and developed an internal plan of correction which included audits of all newly admitted residents in the prior 14 days for hospital order transcription, in-servicing of staff on transcribing hospital orders, ongoing audits of all newly admitted resident's for hospital order transcription, and referral to the Quality Assurance and Performance Improvement program for ongoing monitoring. Staff A stated they had achieved compliance as of 10/25/2024. Review of documentation and review of current facility resident EHR showed facility had achieved compliance as of 10/25/2024. Past noncompliance - no plan of correction required. Reference WAC 388-97-1060 (3)(k)(iii)