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	01/30/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36854 Based on interview and record review, the facility failed to ensure pain medications were available and failed to obtain provider's orders for an alternate pain medication of similar strength, for 1 of 3 sampled residents (Resident 1) reviewed for pain management. This failure placed residents at risk for increased pain and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE] with multiple diagnoses, including chronic pain due to lumbar spine stenosis (narrowing of the spinal canal that can put pressure on the spinal cord and nerves) and degenerative disc disease (cushioning in the spine wears away). The Minimum Data Set, an assessment tool, dated 07/26/2024, documented Resident 1 was alert and oriented, and required assistance with activities of daily living. Resident 1's care plan, dated 12/19/2024 for management of acute/chronic pain, stated staff were to administer analgesia as per orders, monitor/record/report resident complaints of pain or requests for pain treatment, and to notify the physician if interventions were unsuccessful or if there was a significant change from resident's past experience of pain. Review of Resident 1's Medication Administration Record (MAR), showed an active order for a fentanyl transdermal patch (a topical medication used to treat severe pain delivered slowly through the skin) to be placed on the resident's skin every 72 hours (3 days) for chronic pain. An order dated 12/16/2024 at 10:15 PM showed nursing was to check placement of the fentanyl patch every shift, at 6:15 AM, 2:15 PM, and 10:15 PM, and to indicate the place where the patch was located. Review of Resident 1's MAR for December 2024 showed the fentanyl patch was not in place, as indicated by either N/A (not applicable) or an X, and lack of a location, for all three shifts on 12/23/2024, 12/24/2024, and the first shift of 12/25/2024. Review of Resident 1's Medication Administration Record documented a fentanyl patch was removed on 12/23/2024 at 11:46 AM. No application of a new fentanyl patch was documented until a narcotic log entry, dated 12/25/2024 at 10:30 PM, that showed a patch was removed from the medication cart. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/24/2024 6:48 AM nursing progress note documented, Patient reported this morning to have had a tough night due to not having fentanyl patch on. Waiting for a new script to be signed. Review of the MAR documented on 12/24/2024 at 2:15 PM, Resident 1 reported their pain at 10 on the pain scale (0 being no pain and 10 being the worst pain). A 12/25/2024 8:21 PM nursing note documented the on-call provider was notified that the fentanyl patch still had not been received, the provider was to make sure the order was sent to the pharmacy right away. Nursing then documented pharmacy had received the order and would send the fentanyl pain patch out that night. No other alert charting note was located that documented follow-up with Resident 1 while the resident was without a pain medication patch or equivalent. Review of Resident 1's record showed the resident had been without a fentanyl pain patch for 59 hours, 13 hours short of the 3 days the patch was expected to have been in place. A 01/02/2025 provider note documented that Resident 1 had been anxious about the fentanyl patch coming off with body position changes, and asked to change to MS Contin, a longer-acting oral pain medication, and oxycodone as needed for breakthrough pain. On 01/13/2025 at 2:28 PM, Resident 1 said they had gone without a pain patch for a couple of days the month before because the facility was out of them. Resident 1 said they had had a lot of pain, told the staff they were having a lot of pain and was very uncomfortable. Resident 1 said they did not want to get anyone in trouble but it felt as if they really did not care that the resident was out of pain patches. Resident 1 said they were given acetaminophen, but that really did not do anything and the resident remained in a lot of pain. Resident 1 said they later asked to change to a different pain medication because they were worried about it falling off and were concerned because the facility had run out of the patches before. On 01/13/2025 at 4:24 PM, Staff C, a Licensed Practical Nurse, said nursing was supposed to re-order the medications ahead of time to ensure they have enough on-hand. Staff C said if they were out or if there was a delay, they were supposed to check the Cubex (an electronic medication dispensing cabinet) and call the pharmacy for an authorization code, or call the provider to see if there is something else the resident can be given until their medication arrives. On 01/30/2025 at 4:01 PM, Staff B, a Registered Nurse and the facility Director of Nurses, said nursing staff had removed Resident 1's pain patch too early, and Staff B did not know why it was removed if they did not have another pain patch to apply. When asked, Staff B said there were pain patches available in the Cubex, Staff B said nursing staff could have contacted the provider to inquire about a substitute pain medication of similar strength to treat Resident 1's pain until the pain patches were received. Reference WAC 388-97-1060(1)