STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135006	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke's Elmore Long Term Care	895 North 6th East Mountain Home, ID 83647

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) had correct assessment information. This was true for 1 of 10 residents (Resident #4) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: The Resident Assessment Instrument (RAI), revised 10/1/24, documented if a PASARR (Preadmission Screening and Resident Review) level II determined a resident has a serious mental illness then section A1500 of the MDS should be marked yes. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including bipolar disorder (a mental health condition characterized by significant mood swings) and anxiety disorder. Resident #4's medical record documented a PASARR level II, dated 7/11/22, was completed. Resident #4's admission MDS assessment, section A1500, dated 7/20/22, documented, no, indicating Resident #4 did not have a PASARR level II. Resident #4's annual MDS, section A1500, dated 7/11/23, and 7/11/24 documented no, indicating Resident #4 did not have a completed PASARR level II. On 1/23/25 at 2:06 PM, the MDS Coordinator stated it appears EPIC (the facility's electronic health record) and the MDS are worded differently for section A1500. The MDS Coordinator stated, I should have marked, yes, based on the MDS wording, as Resident #4 did have a PASSAR level II.

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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193 Based on observation, staff interview, policy review and record review, it was determined the facility failed to ensure medications were administered according to professional standards of practice. This was true for 1 of 1 resident (Resident #7) whose medications were observed in the medication cup inside the medication cart. This failed practice created the potential for residents to experience adverse effects when their medications were not administered according to the physician's order. Findings include: The facility's Medications - Ordering, Dispensing, Administration, Monitoring and Storage policy, revised 11/12/24 documented medications prescribed frequently than daily, but no more frequently than every 4 hours (ex: QID, TID, BID) may be administered within a window of 2 hours before or after the standardized scheduled time. Resident #7 was admitted to the facility on [DATE], with multiple diagnoses including stroke and dementia. A physician's order, documented Resident #7 was to receive the following medications: - Allegra (antihistamine) tablet 180 milligrams once a day, - Metformin tablet 1,000 two times a day with meals, dated 7/26/24, - acetaminophen 650 mg two times daily, dated 6/27/24, and - lactulose (laxative) 20 gram/30 ml (milliliter) three times a day, dated 3/6/24. -Vitamin D3 1,000 units daily. On 1/22/25 at 1:13 PM, during the inspection of the Long Hall Medication cart with ADON present, a medication cup containing two round white tablets, one oval pink tablet, one white oval tablet, one small tablet, and next to the medication cup was an unopened cup of lactulose 20 grams/30 milliliter was observed inside the medication cart. The medication cup was inside another container with Resident #7's name. When asked about the medications, ADON looked at the medications and paused before responding. ADON then stated she prepared Resident #7's medications and when she was about to administer them, Resident #7 stated he needed to go to the restroom. ADON stated when she went back to Resident #7's room, he was not in his room. ADON stated she put the medication cup back inside the medication cart with Resident #7's name. When asked what time the medications should have been given to Resident #7, the ADON stated it was due at 8:00 am. ADON stated she got distracted and was not able to give them to Resident #7.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40733 Based on record review, review of facility policies and procedure, review of Incidents and Accidents (I&As) reports, and staff interview, it was determined the facility failed to ensure residents were protected from significant medication errors. This was true for 2 of 3 residents (#14 and 170) reviewed for medication errors. This deficient practice created the potential for Resident #170 to experience harm when he was administered another resident's medications, and for Resident #14 when he received the wrong dose of insulin. Findings include: The facility's policy, Medications - Ordering, Dispensing, Administration, Monitoring and Storage, documented, medications will be administered according to the following rights of medication: The right patient, right medication, right dose, right time, right route, and right documentation. 1. A facility I&A report, dated 5/1/24, documented, during the morning medication rounds, Resident #170 received 8 medications meant for another resident. The medications included: Three medications Resident #170 was not prescribed: Vitamin C 500 mg, Vitamin B-12 100 mcg, and Ferrous sulfate 325 mg. Three medications at different doses than the ones he took: Vitamin D-3 1000 units (5000 units intended), Cymbalta (an anti-depressant) 20 mg (60 mg intended), and Metformin (an anti-diabetic) 1000 mg (500 mg intended). Two medications at different times than the ones Resident #170 took: Tamsulosin (a treatment for an enlarged prostate) 0.4 mg, and Finasteride (a treatment for an enlarged prostate). Immediately after discovering the error, the nurse notified Resident #170's physician and began monitoring for him for adverse effects. Resident #170's record documented no adverse effects manifested. Resident #170's family was notified, and nursing staff were re-educated on the 6 rights of medication and the procedure for scanning medications at the bedside. 2. A facility I&A report, dated 7/13/24, documented Resident #14 was administered 10 units of Semglee (a long-acting insulin) instead of his ordered dose of 14 units. Immediately upon discovering the error, the nurse notified Resident #14's physician, who recommended monitoring Resident #14 and no additional dosing to be given. Residents #14's record documented no adverse effects were noted during the monitoring. The report documented the facility's DON, Administrator, and Resident #14's family were notified of the error. The nurse was reeducated on the importance of following the 6 rights of medication administration. On 1/23/25 at 3:05 PM, the DON was interviewed. She confirmed Resident #14 and Resident #170 experienced medication administration errors. The DON stated the facility has an ongoing Quality Improvement project to address medication errors. She confirmed the project includes Resident #14's and Resident #170's error events.