STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135092	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Rock Health and Rehabilitation of Cascadia	840 East Elva Street Idaho Falls, ID 83401

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure physician orders were followed for 1 of 9 residents (Resident #2) whose records were reviewed for quality of care related to following medication and treatment orders. This failure created the potential to adversely affect residents whose care and services were not delivered according to their physician orders. Findings include: Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including olecranon (elbow) fracture, Parkinson's Disease, and acute respiratory failure. Her record documented medication administration discrepancies including an AM medication given in the evening and medications crushed into food without an order. Resident #2's record included 32 Daily Skilled Nursing Notes, between the dates of 7/5/24 through 8/13/24, documented Resident #2's medications were crushed and added to applesauce, pudding, or yogurt when given to her. On 8/12/24 at 12:31 PM, LPN #4 stated she worked as the day nurse on 8/4/24 and gave report to the evening nurse, LPN #1, and told her Resident #2 needed her medications crushed and added to applesauce per recommendations from the Speech Therapist. Resident #2's record did not document an order to crush medications and add to applesauce, pudding, or yogurt. Resident #2's scheduled medication orders included: - Levothyroxine Sodium oral tablet 50 mcg to be given once a day at 5:30 AM. - Benztropine Mesylate oral tablet 1 mg at bedtime. - Bupropion HCl 75 mg every morning and at bedtime. - Clonazepam 1 mg every morning and at bedtime. - Donepezil HCl 10 mg (0.5 tablet every morning and at bedtime). - Doxycycline Hyclate 100 mg every morning and at bedtime. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Memantine HCl 10 mg every morning and at bedtime. On 8/13/24 at 10:22 AM, LPN #1 was interviewed and stated, on 8/4/24, she crushed 7 of Resident #2's medications (Benztropine, Clonazepam, Levothyroxine, Doxycycline, Bupropion, Donepezil, and Memantine) and added them to applesauce before giving them to her. When asked why she gave Resident #2's Levothyroxine with her bedtime medications when it was ordered to be given at 5:30 AM. LPN #1 stated she knew it was scheduled for the morning, but a lot of residents get mad about getting woken up that early in the morning and I was told Resident #2 was one of them. On 8/14/24 at 12:39 PM. the DNS and Regional Clinical RN were interviewed together and Resident #2's record was reviewed in their presence. When asked if there was an order for Resident #2's medications to be crushed and added to foods, they stated they were not and were not aware her medications were being crushed without an order. The Regional Clinical RN stated, We fixed that and got the order yesterday after you alerted us about it. When asked if Resident #2's Levothyroxine, ordered to be taken at 5:30 AM, was approved by her physician to be given in the evening? The DNS stated she was not aware nurses were giving Levothyroxine at night when it was ordered to be given at 5:30 AM. She stated, if the time needed to be changed, there needed to be an order for it.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981 Based on observation, record review, and staff interview, it was determined the facility failed to ensure medications were reconciled and removed from a medication cart when discontinued for 1 of 3 medication carts observed. This was true for 1 of 19 residents (Resident #105) and created the potential for harm for 19 residents who received medications from the cart due to an increased risk for medication administration errors. Additionally, this failure created an increased risk for medication diversion. Findings include: Resident #105 was admitted to the facility on [DATE], with multiple diagnoses including metabolic acidosis (a buildup of too much acid in the body resulting in kidney failure), diabetes, and hypertension. On 10/29/24 at 3:45 PM, the facility's medication cart for the 200 and 400 halls was inspected with LPN #1 present. LPN #1 was observed to remove a blister pack from the cart and began to prepare a medication disposal kit to destroy the medication. The blister pack contained 31 tablets of the controlled medication hydrocodone (a semi-synthetic opioid used to treat pain) 5/325 mg which was prescribed to Resident #105. Resident #105's MAR documented a physician order for hydrocodone 5/325 mg was discontinued on 10/12/24. On 10/29/24 at 3:50 PM, LPN #1 stated Resident #105's hydrocodone 5/325 mg should have been removed from the medication cart the day it was discontinued. On 10/30/24 at 12:00 PM, the CRN stated when an opioid medication order is discontinued, the nurse manager should remove it from the cart by the next working day.

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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** 50981 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were protected from significant medication errors. This was true for 2 of 4 residents (#1 and #3) reviewed for medication errors. This deficient practice created harm for one resident (Resident #1) who was hospitalized , and the potential for harm for one resident (Resident #3), due to receiving the wrong medications. Findings include: The facility's Medication Errors policy and procedure, release date 11/28/2017, documented a medication error as the administration of drugs or biologicals which is not in accordance with prescribers' orders, manufacturers specifications, and accepted professional standards. Significant Medication Error as one which causes the resident discomfort or jeopardizes his or her health and safety. 1. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including encephalopathy (a group of conditions that cause brain dysfunction), high blood pressure, and dysphasia (difficulty swallowing). A progress note dated 8/4/24 at 11:30 PM, by LPN #1, documented Resident #1 was transferred to the hospital via EMS (Emergency Medical Services) with noted changes in condition (altered mental status, decreased oxygen levels, and decreasing blood pressure) after being administered Resident #2's medication. On 8/13/2024 at 10:22 AM, LPN #1 was interviewed, she stated, on the evening of 8/4/24, she was assigned to work a hall unfamiliar to her. She recalled LPN #4 informing her during hand-off report, of Resident #2's room change within the same hall. LPN #1 stated, later that shift during her medication pass, she prepared Resident #2's medications by crushing them and adding them to applesauce. The medications included: - Benztropine Mesylate, 1 mg, an anti-tremor Parkinson's medication - Bupropion HCl, 75 mg, an anti-depressant - Clonazepam, 1 mg, a long-acting tranquilizer for anxiety - Donepezil HCl, 10 mg, an Alzheimer's medication to treat dementia - Doxycycline Hyclate, 100 mg, an antibiotic - levothyroxine, 50 mcg, a hormone to treat hypothyroidism (contraindicated in those with high blood pressure) - Memantine,10 mg, medication to treat dementia. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	She took the prepared medications to Resident #2's previous room which was empty. She then stored the medications in the medication cart until she could locate Resident #2's new room. LPN #1 stated she continued her medication rounds and prepared Resident #1's evening medications which included one Lipitor tablet (a cholesterol-lowering medication), which she refused. When LPN #1 returned the Lipitor to the medication cart, she noticed the medications she had prepared earlier for Resident #2, who had the same first name as Resident #1. LPN #1 stated she confused Resident #1 for Resident #2 and took the prepared medications, stored for Resident #2, to Resident #1, who accepted and took the medications. LPN #1 stated, a few minutes later, she noticed Resident #2's new room across the hall and realized she had given her medications to the wrong resident. Hospital notes, dated 8/5/24, documented Resident #1 was brought in due to receiving the wrong medications at the skilled nursing facility. The hospital documented Resident #1 had atrial fibrillation (a type of irregular heart rhythm which prevents blood from flowing properly to the lower chambers of the heart), tachycardic (fast heart rate) and hypotension (low blood pressure) when she arrived at the hospital. On 8/13/24 at 12:39 PM, the DNS and Regional Clinical RN were interviewed together and confirmed that Resident #1 was given Resident #2's medications then transferred to the hospital for further monitoring. 2. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease, chronic kidney disease, fibromyalgia, and diabetes. A Medication Error Report, dated 8/13/24, documented a medication error occurred on 8/11/24 at 6:20 PM when LPN #3 reported she may have given Resident #3 the wrong insulin. Resident #3's insulin order was for NovoLog (a rapid-acting insulin) per sliding scale at meals and bedtime, and LPN #3 may have given Lantus (a long-acting insulin) instead. She immediately reported the suspected error to Resident #3's physician who ordered blood sugar monitoring every 6 hours for 24 hours. On 8/13/24 at 5:33 PM, LPN #3 was interviewed regarding the medication error. She stated she checked Resident #3's blood sugar and followed up by giving her an insulin dose, then was not sure if she administered Lantus or Novolog so she notified the physician immediately and started to monitor Resident #3 for adverse symptoms. Resident #3's record documented she did not require further medical interventions for a change in condition. On 8/13/24 at 12:39 PM, the DNS and Regional Clinical RN were interviewed and confirmed LPN #3 was not sure which insulin she gave Resident #3 on 8/11/24.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981 Based on observation, record review, and staff interview, it was determined the facility failed to ensure medications were labeled correctly for 1 of 3 carts observed. This failure created the potential for harm if the resident who was prescribed the medication (Resident #104) received the wrong dose of his medication. Findings include: Resident #104 was admitted to the facility on [DATE], with multiple diagnoses including left arm fracture, heart failure, hypertension (high blood pressure), and pain. Resident #104's October 2024 MAR documented her prescribed oxycodone (a semi-synthetic opioid used for pain) 5 mg every four hours as needed for pain was discontinued on 10/24/24 and replaced with a new order for oxycodone 5 mg, four times a day (every 6 hours). On 10/29/24 at 3:45 PM, the 300 Hall medication cart was inspected with LPN #1 present. Resident #104's blister pack label for her oxycodone 5 mg stated every 4 hours as needed. The label did not reflect the updated order of four times a day (every 6 hours). On 10/29/24 at 3:50 PM, LPN #1 stated they should have placed a sticker on the blister pack to indicate the medication order change on 10/24/24. On 10/30/24 at 12:00 PM, the CRN stated, when an order is changed, nursing staff should place a sticker on the blister pack indicating there is a new order, pass the update along in report, add it the communication board, and initiate alert charting in the MAR.