

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Eagle Rock Health and Rehabilitation of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure resident centered care plans were comprehensively written for 4 of 17 residents. This was true for residents (#6, #8, #34, and #36) reviewed for care plans. This deficient practice placed the residents at risk for harm when their care plans did not reflect the care necessary for each resident. Findings include:</p> <p>The CMS SOM, Appendix PP, dated 8/8/24, documented, each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences, goals, and address the resident's medical, physical, mental and psychosocial needs.</p> <p>1. Resident #6 was admitted to the facility on [DATE] with multiple diagnoses including metabolic encephalopathy (a condition where brain function is disrupted due to imbalances in the body's metabolism, leading to symptoms of confusion and impaired motor skills), Parkinson's disease, and dementia.</p> <p>Resident #6's care plan, last reviewed 12/5/24, did not include directions to care for her diagnosis of dementia.</p> <p>On 2/20/25, at 12:10 PM, the CEO stated, Resident #6's care plan should have included directions to care for her diagnosis of dementia, but the care plan did not.</p> <p>2. Resident #34 was admitted to the facility on [DATE] with multiple diagnoses including heart failure and chronic kidney disease, prostate cancer, and urinary retention.</p> <p>Resident #34's medical record documented a physician order on 11/17/24 for placement of a indwelling urinary (foley) catheter.</p> <p>Resident #34's care plan, last reviewed 11/29/24, did not include directions to care for his foley catheter.</p> <p>On 2/20/25 at 12:10 PM, the CEO stated, Resident #34's care plan should have included directions to care for his foley catheter, but the care plan did not.</p> <p>36193</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Resident #36 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a progressive lung disease characterized by increasing breathlessness).</p> <p>An Admission MDS assessment, dated 3/3/24 documented it was somewhat important for Resident #36 to have books, newspapers, and magazines to read; listen to music he likes; to do things with group of people, and be around animals such as pets.</p> <p>Resident #36's care plan, dated 12/14/24, did not address his preferences for his activities.</p> <p>Resident #36 was observed in his room on 2/18/25 at 4:28 PM. A calendar of activities was observed posted on the wall by the door. Resident #36 stated he was not interested in participating in any of the activities in the facility. Resident #36 was again observed to be in his room on 2/19/25 at 10:12 AM, and on 2/20/25 at 9:27 AM, sitting on his bed. There were no books, newspapers, or magazines observed in his room.</p> <p>On 2/20/25 at 10:51 AM, the CEO reviewed Resident #36's care plan, and stated he did not have an activity care plan and he should have one.</p> <p>50981</p> <p>4. Resident #8 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including chronic kidney disease, and neuropathic bladder (a lack of bladder control).</p> <p>A physician's order dated 12/2/24, documented an order to place a foley catheter including care and maintenance.</p> <p>Resident #8's care plan, dated 1/27/25, did not include any focus, goals, or interventions related to the foley catheter.</p> <p>On 2/20/25 at 12:00 PM, the CEO confirmed a care plan should have been developed to reflect these new orders for Resident #8.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current needs and interventions. This was true for 1 of 17 residents (Resident #8) whose care plans were reviewed. This deficient practice created the risk of adverse outcomes if care and services were not provided due to care plans not being revised as resident's needs changed. Findings include:</p> <p>The CMS SOM, Appendix PP, dated 8/8/24, documented a resident's care plan must be reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions.</p> <p>Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including bipolar and psychotic disorders.</p> <p>Resident #8's physician orders documented:</p> <ul style="list-style-type: none"> -Depakote (anticonvulsant to treat bipolar) was discontinued on 6/20/24. -Mirtazapine (antidepressant) was discontinued on 6/20/24. -Lorazepam (antianxiety), as needed, discontinued on 11/11/24. <p>Resident #8's care plan, initiated on 5/24/23, documented resident used antidepressant medications related to bipolar disorder and depression.</p> <p>On 2/20/25 at 12:00 PM, the CEO confirmed Resident #8's care plan should have been updated to reflect a change in physician's orders when her medications were discontinued, and it did not.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36193</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents received oxygen therapy per physician orders. This was true for 1 of 4 residents (Resident #36) reviewed for oxygen therapy. This deficient practice created the potential for harm if residents' respiratory needs were not met. Findings include:</p> <p>The facility's Oxygen Therapy policy and procedure, revised 8/4/23 directed staff to verify physician's order prior to initiating oxygen therapy.</p> <p>Resident #36 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a progressive lung disease characterized by increasing breathlessness).</p> <p>A care plan, initiated 2/26/24, documented Resident #36 used supplemental oxygen related to shortness of breath. The care plan directed staff to administer oxygen via nasal cannula as ordered.</p> <p>A physician assistant's progress notes, dated 2/19/24, documented Resident #36 had oxygen levels greater than 92 percent on multiple occasions while maintaining two liters of oxygen. The physician assistant ordered to decrease supplemental oxygen down to one liter to adhere to 88 to 92 percent of oxygen saturations as this may be contributing to carbon dioxide retention and abdominal pain.</p> <p>Resident #36's physician's orders, included oxygen one liter per minute (LPM) continuously via nasal cannula every shift related to COPD, ordered on 2/19/25.</p> <p>On 2/20/25 at 9:27 AM, Resident #36 was observed in his room receiving oxygen therapy via nasal cannula. The oxygen condenser was set to deliver two LPM. The surveyor then asked RN #1 to confirm the physician's order for Resident #36's oxygen. RN #1 reviewed the physician's order and stated it was one LPM. RN #1 with the surveyor went to Resident #36's room and checked his oxygen flow rate. RN #1 confirmed the oxygen was set at two LPM and it should have been set at one LPM.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981</p> <p>Based on record review, medication error 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 2 residents (#42 and #48) reviewed for medication errors. This deficient practice created the potential for harm if residents received the wrong dosage of medications. Findings include:</p> <p>The facility policy for Oral Medication Administration, dated 1/1/18, included the direction for nursing staff to validate the order against the medication packaging, confirm correct dose, correct route, and time/frequency.</p> <p>1. Resident #42 was admitted to the facility on [DATE], with multiple diagnoses including amputation of the left and right great toe, gangrene (a condition where the tissue dies due to lack of blood supply), and disease of the spleen.</p> <p>A Medication Error Report, dated 1/13/25, documented the following:</p> <p>-A photocopy of a prescription, dated 1/7/25, documented oxycodone (a narcotic used to treat pain), 5 mg tablet, give 10 mg by mouth every four hours as needed for pain scale 4-8, use 1-2 tablets as needed for pain every 4 hours.</p> <p>-The order transcribed into the Medication Administration Record (MAR) documented oxycodone 10 mg give 1 tablet every 4 hours as needed for pain scale 4-10.</p> <p>-A controlled drug record form documented Resident #42 received 5 mg of oxycodone on the following dates and times:</p> <ul style="list-style-type: none"> -1/8/25 at 9:00 PM -1/9/25 at 10:00 AM -1/9/25 at 11:30 PM -1/10/25 at 6:33 AM -1/10/25 at 2:17 PM -1/10/25 at 8:04 PM -1/11/25 at 7:05 AM -1/11/25 at 12:48 PM <p>-On 1/11/25 LPN #1 recognized the order in the MAR did not match the directions on the medication card.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Medication Error Report concluded a medication error occurred 8 times on 1/8/25, 1/9/25, 1/10/25, and 1/11/25 when the administering nurses documented they administered 10 mg of oxycodone in the MAR, when the medication card and controlled drug record documented he received 5 mg at each administration.</p> <p>On 2/20/25 at 3:57 PM, the CEO confirmed the medication strength administered did not match the medication strength written in the MAR on 1/8/25, 1/9/25, 1/10/25, and 1/11/25. The CEO added, the dosage and pain scale discrepancies should have been clarified and correctly transcribed by each nurse handling the medication.</p> <p>2. Resident #48 was admitted to the facility on [DATE] with multiple diagnoses including diabetes, chronic pain, and rheumatoid arthritis.</p> <p>Resident #48's MAR documented an order change on 12/13/24, for Lyrica (a medication used for nerve pain), to increase the dose from 100 mg twice daily to 100 mg in the morning and 150 mg every night at bedtime.</p> <p>A Medication Error Report, dated 12/19/24, documented a medication error occurred on 12/16/24, 12/17/24, and 12/18/24 when it was discovered that LPN #2 gave Resident #48 100 mg of Lyrica instead of the prescribed 150 mg at bedtime.</p> <p>On 2/20/25 at 4:00 PM, the CEO confirmed LPN #2 administered Resident #48 the wrong dose of Lyrica at bedtime on 12/16/24, 12/17/24, and 12/18/24.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50603</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to maintain kitchen sanitation and food storage at least 6 inches above the floor. These deficiencies had the potential to affect the 53 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes due to contaminated food and food services equipment. Findings include:</p> <p>1. The Food and Drug Administration (FDA) Food Code Section 3-305.11, documented: (A) Food should be protected from contamination and stored in a clean, dry location where it was not exposed to splash, dust, or other contamination; and at least 6 inches above the floor.</p> <p>On 2/18/25, at 1:20 PM and 2/20/25 at 3:35 PM, it was observed the kitchen pantry shelves contained food items which were located 4.5 inches above the floor.</p> <p>On 2/20/25 at 3:40 PM, the Culinary Director confirmed the shelves containing food items were only 4.5 inches above the floor.</p> <p>2. FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils, documented: (E) Surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned: (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.</p> <p>On 2/18/25, at 1:19 PM, and 2/20/25, at 3:27 PM, the inside of the kitchen ice machine along the white panel it was observed with a pink slimy substance.</p> <p>On 2/20/25 at 3:30 PM, the Culinary Director and Registered Dietitian confirmed there was a thin pink line along the ridge of the white panel located inside the ice machine.</p> <p>3. The FDA Code Section 4-602.12 Cooking and Baking Equipment, documented: Food-contact surfaces of cooking equipment must be cleaned to prevent encrustation's that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use.</p> <p>On 2/18/25, 1:15 PM and 2/20/25, at 7:30 AM and 3:20 PM, kitchen cookware (sheet pans, pots, and food skillets) was observed which had black residue encrusted along the bottom rims, along the corners, and in the interior cook area.</p> <p>On 2/20/25 at 3:25 PM, the Culinary Director and Registered Dietitian confirmed the skillets and cookware were older, but all kitchen cookware was cleaned and sanitized as per manufacturers recommendations. They did not know why the cookware had black residue when they had been cleaned and sanitized.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4. The FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions, documented: The cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner.</p> <p>On 2/18/25, 1:20 PM and 2/20/25 at 3:15 PM, it was observed in the kitchen walk-in refrigerator, a layer of dust particles was hanging from the ceiling in front of the condenser fans.</p> <p>On 2/20/25, at 3:17 PM, the Culinary Director verified there were dust particles on the ceiling of the walk-in refrigerator.</p>		