

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/23/2026
NAME OF PROVIDER OR SUPPLIER  Rockwood South Hill		STREET ADDRESS, CITY, STATE, ZIP CODE  East 2903 25th Avenue Spokane, WA 99223	

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 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>Based on interview and record review, the facility failed to transcribe provider orders correctly and administer medications as intended by the provider for 1 of 6 sampled residents (Resident 31), reviewed for unnecessary medications. This failure placed residents at risk of adverse side effects and unnecessary medications. Findings included .According to the 01/19/2026 admission assessment, Resident 31 was admitted with diagnoses to include a mental health disorder. The resident was able to make their needs known.Review of the 01/05/2026 admission orders showed the resident took Seroquel (chemical substances that affect brain function, altering mood, thoughts, behavior, or perception to treat mental health conditions) 25 milligrams (mg) once a day.Resident 31's Medication Administration Record (MAR) for January 2026 and February 2026 showed an order was entered on 01/05/2026 for Seroquel 25 mg once a day, give .5 mg in the evening. The MAR showed the resident received a 1/2 tablet (12.5 mg) of Seroquel from 01/05/2026 through 02/09/2026 every evening.Review of a 02/09/2026 facility investigation, showed the resident admitted with an order of Seroquel 25 mg every evening and the order was transcribed incorrectly into the MAR as Seroquel 25 mg once a day, give .5 mg. The pharmacy sent 12.5 mg (1/2 tablet of 25 mg) which was administered to the resident from 01/05/2026 to 02/09/2026. The provider was notified of the medication error.In an interview on 03/19/2026 at 2:50 PM, Staff C, Resident Care Manager (RCM), stated they had investigated the medication error for Resident 31. When asked about their process for placing orders into the MAR when a resident was admitted to the facility, Staff C stated the nurse would place the orders into the computer and print them, a second nurse did not review the orders for accuracy. The process had been changed after the medication error for Resident 31 was identified, and now one nurse entered the order, a second nurse reviewed them, and both nurses would sign the orders.In an interview on 03/20/2026 at 2:00 PM, Staff B, Director of Nursing (DNS), confirmed the order for Resident 31's Seroquel was transcribed incorrectly, and the resident received the wrong dose. Reference: WAC 388-97-1060(3)(k)(iii)</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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