STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275026	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 41652 Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission, for 1 (#86) of 31 sampled residents. Findings include: Review of resident #86's baseline care plan, dated 12/4/23, showed the following areas of concern were identified on the baseline care plan: - at risk for falls, - the presence of pain, - required dialysis for ESRD; and, - required insulin for the treatment of diabetes mellitus. None of the above areas of concern on the baseline care plan for resident #86 showed any goals or interventions to be used by staff to perform resident cares. During an interview on 3/28/24 at 8:39 a.m., staff member B stated the staff nurse or the unit manager was responsible for initiating the baseline care plan. Staff member B stated she it was her expectation the staff would complete goals and interventions for areas of concern identified on a resident's admission. Staff member B was not aware of the issue with the baseline care plans not being completed with necessary information for new admissions.

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50245 Based on observations, interviews, and record reviews, the facility failed to identify, assess, treat, document, monitor, and implement sufficient interventions for a resident who utilized an immobilizer, and developed a wound, which resulted in an avoidable Stage IV pressure ulcer, for 1 (#14); failed to obtain or follow physician treatment orders for wound care, accurately assess and document the status of an avoidable wound and it progressed to a Stage III, for 1 (#8); and failed to ensure treatment orders (ear pads) for ear wounds were clarified and wound interventions were in place, well, and followed, for a resident who did not like and who removed the ear pads, for 1 (#94), and the ear wound worsened, for 4 sampled and supplemental residents reviewed for pressure ulcers. Findings include: 1. During an interview on 3/27/24 at 11:14 a.m., staff member I stated resident #14's initial goal was to go home. Staff member I stated, There is no excuse with her (#14's) wounds because she did not come here with the wounds. Staff member I stated the nurses are expected to follow physician orders, communicate with the provider/wound care nurse, offer protein supplements, turn the resident every two hours, and encourage ambulation when working with resident #14's wounds,and the wounds would have been avoidable. During an interview on 3/28/24 at 4:00 p.m., staff member DD stated resident #14 had skin breakdown from the (leg) immobilizer on the upper thigh and back of the lower calf. Staff member DD mentioned resident #14 had anxiety, fear, and a harder time following directions due to her level of cognition. Staff member DD stated resident #14 would not always follow weight bearing orders when ambulating, and staff would leave the immobilizer on more for safety and an extra precaution. Record review of resident #14's current coccyx wound orders, as of 3/28/24, showed: Coccyx: Clean area with NS, pat dry, Vashe-soaked gauze to wound covered with bordered foam dressing. Change dressing daily. During an observation on 3/28/24 at 4:58 p.m., NF6 dressed resident #14's coccyx wound with xerform gauze, then an optifoam. The dressing was not dated, and the treatment was different from the current wound treatment orders. When observing the appearance of the wound, there was generalized redness to the coccyx area with a small area of yellow that was not near the two open skin areas. These wounds were superficial and had redness in both wound beds. Review of resident #14's EHR, related to concerns with the development and progression of her pressure ulcer(s), showed: - Resident #14's nursing progress note, dated 11/29/23 (admitted), showed, . Skin is normal, warm/dry to touch . There are no changes noted in residents skin integrity . and on 12/26/23, the notes showed, . Skin is normal, warm/dry to touch . - Resident #14's physician's progress note, dated 12/28/23, showed no information of any skin conditions at that time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Resident #14's nursing progress note, dated 12/29/23, showed the first documentation of a wound to the left lower extremity. This wound had measurements of 6.0 cm by 3.2 cm by 1.2 cm. The note showed, . removed old dressing, there was a large amount of drainage . - Resident #14's Weekly Nurses Skin Observation note, dated 12/31/24, showed, . wound to LLE 7.0 x 2.5 x 1.5 there is dead tissue, foul odor . - #14's physical therapy note, dated 1/2/24, showed PT removed long knee immobilizer and issued patient a short version (of immobilizer) to protect wound from pressure. Noted that wound area is wrapped in ace bandaged with metal clips, removed metal clips and reinforced dressing with silicone dressing to hold dressing in place and prevent further pressure on wound . [sic] - #14's nurses notes, dated 1/2/24, showed, Knee Immobilizer splint (L) lower leg, Monitor for placement every day and night shift brace has been placed on the resident. Therapy has given her a shorter brace that appears to be working out for the best. it is not touching the wound area. - #14's Weekly Pressure Wound Observation Tool, dated 1/8/24, showed left lower leg rear pressure wound at a Stage IV with measurements of 8.0 cm by 3.9 cm by 1.0 cm. The wound advanced to the Stage IV, but prior to 1/8/24, this wound had not been staged by any staff, even with the measurements obtained on 12/29/23. - #14's Weekly Nurses Skin Observation Note, dated 1/14/24, showed a left lower extremity wound with measurements to be 7.0 cm by 2.5 cm by 1.5 cm, and the wound had a foul odor and dead tissue. - #14's Weekly Pressure Wound Observation Tool, dated 1/23/24, showed a left lower leg rear pressure wound at a Stage IV with measurements of 8.0 cm by 3.9 cm by 1.0 cm. - Review of #14's EMR, showed resident #14 was placed on hospice on 2/5/24. The resident's left lower calf pressure ulcer wound care orders were initiated (2/15/24), after the hospice order was in place. - #14's wound nursing note, dated 2/12/24, showed the wound measurements were 5.1 cm by 1.5 cm by 0.9 cm. - #14's wound care orders between 12/29/23 and 2/14/24, showed orders were provided from [Clinic Name], but these specific wound care orders were not placed in resident #14's EMR from 12/29/23 to 2/14/24. The first wound care order placed for the resident's left lower calf wound was significantly delayed, even though the wound was a Stage IV. - #14's initial wound care orders were placed for the left posterior leg pressure ulcer on 2/15/24. - #14's physician order placed 2/20/24, showed, Use pressure reducing pillow placed between legs while (resident) positioned on her side in bed allowing reduced pressure to Sacrum and Calf. Do not allow resident to remain in same position for extended amounts of time and to rotate from side to side. **Not meant for under calve every day and night shift for preventative measure. [sic] (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- #14's physician order placed 2/29/24, showed med pass was utilized for weight loss/management. Med pass was not placed for wound prevention. -#14's physician order placed 3/16/24, showed Pro-stat was ordered one time a day for wound healing. The resident's Pro-stat orders were initiated after the hospice order was in place (2/5/24) and 2 and 1/2 months after the wound was first documented (12/29/23). - #14's physician notes, dated 3/19/24, showed a left lower leg pressure ulcer at a Stage III with measurements of 5.0 cm by 1.3 cm by 0.8 cm. This was inconsistent with prior documentation. - #14's dietary note, dated 3/19/24, showed, .continued unavoidable weight loss . No documentation in the nutritional note showed resident #14's left lower leg pressure ulcer was unavoidable. - #14's physician note, dated 3/26/24, showed, . Noted that wound dressings are dated 3/24/24; LLE wound dressing should be changed daily . - #14's physician note, dated 3/26/24, showed measurements of the left lateral calf pressure ulcer as 4.5 cm x 1.0 cm x 0.4 cm, but the weekly Pressure Wound Observation Tool showed different measurements of the left lateral calf pressure ulcer as 4.5 cm x 1.3 cm x 0.4 cm, showing inconsistency. Staff member M was documented as being present for both of these skin assessments. - #14's EMR showed the Weekly Pressure Wound Observation Tool, dated 3/26/24, showed the left lower calf pressure ulcer was a Stage II upon admission. This documentation differs from all documentation upon admission on 11/29/23, and an interview with staff member I, on 3/27/24 at 11:14 a.m. - Review of resident #14's current (as of 3/28/24) left lower calf wound orders: Pressure Ulcer: Left posterior leg Care Instructions: **Family to supply Vashe** 1. Clean wound with NS or equiv 2. Apply Vashe moistened gauze to wound daily 3. Cover with ABD pad and secure with kerlix and tape. 4. Wear Rooke boots daily Orders received from [NF5 Name] via [Wound Clinic Name] PER FAMILY REQUEST, do not change or d/c orders. During an observation on 3/28/24 at 4:58 p.m., resident #14's left lower leg wound was located on the rear side of the calf, halfway between the ankle, and her knee. When observing the appearance of the wound, it was noted there was slight redness around the opening of the wound. The wound was deep into the skin, but no tendon, bone or muscle was observed. A small amount of yellow exudate was in the wound. Staff member C used tap water to moisten a washcloth to loosen the dry gauze packing located in resident #14's left lower rear calf wound. Record review of the current wound care orders for the left lower calf wound, showed no packing ordered for the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During the observation on 3/28/24 at 4:58 p.m., staff member C stated she was unable to stage resident #14's wound. NF6 stated resident #14's left lower rear calf wound was a Stage III pressure ulcer because it had slough. Staff member C stated a wound cannot be a Stage III if it has slough. After speaking with staff member C, NF6 later stated the wound was a Stage IV pressure ulcer because the wound was tunneling. Record review of resident #14's TAR, dated March of 2024, showed 11 missed dressing changes in March 2024 for the left lower rear calf wound. Record review of resident #14's March 2024 TAR also showed seven missed days of documented repositioning for relief of pressure to the skin. Record review of resident #14's EMR showed two missed weekly skin evaluations in March 2024 (3/6/24 and 3/20/24). 2. During an interview and observation on 3/25/24 at 2:06 p.m., resident #8 stated she was leaning to the left in her wheelchair because the right side of her bottom (buttock area) hurt. - #8's wound clinic treatment orders were provided by the facility, for 11/28/23 and 1/5/24, but neither of these orders were entered into the EMR for resident #8. Therefore, the orders were not followed by nursing staff, and further deterioration may have been avoidable. Record review of resident #8's wound care physician orders and the nursing notes showed the type of dressing used for resident #8's left buttock wound, but failed to show a specific wound location until 1/23/24. The notes showed: - A wound order, dated 1/5/24 to 1/17/24, showed, 1 Application applied 3 times a week to wound. - Record review of resident #8's EMR showed inconsistencies in wound measurements and pressure ulcer staging on 1/5/24. The notes did not show the wound was unavoidable. - A physician note on 1/5/24 showed an Unstageable pressure ulcer with no location specified while a nursing note on 1/5/24 showed a Stage III pressure ulcer upon admission. - A wound care order, dated from 1/9/24 to 1/18/24, showed wound care was to be completed for a Peri wound and a wound bed. Nursing notes showed resident #8 had multiple wounds. - The nursing note, dated 1/12/24, included a coccyx wound, but another nursing note, dated 1/13/24, one day later, showed a pressure wound on #8's left buttock. - A nursing note, dated 1/12/24, showed need order clarification regarding this wound order. - Lastly, the wound care order, dated 1/18/24, failed to identify the location of the wound as it showed, Cleanse with NS wound wash and pat dry with gauze . - Record review for #8 showed inaccurate wound measurements on 2/5/24. A nursing note showed the pressure ulcer was a Stage IV with measurements of . 2.5cm by 1.5cm by 2.0cm by 3.3cm. [sic]. Pressure ulcer wounds are measured length x width x depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- The record review of the provider orders for resident #8, showed the facility failed to have wound care orders for the right buttock wound, for the day 2/6/24. - No wound size measurements were then documented until 2/12/24, and they were 2.1 cm by 2.0 cm by 1.6 cm. Record review of resident #8's EMR showed a physician note on 3/7/24 that staged a pressure ulcer as a Stage III with measurements of 1.0 cm by 0.8 cm by 3.5 cm. Record review of #8's Weekly Pressure Wound Observation Tool, dated 3/12/24, showed the right buttock pressure ulcer at a Stage III, with measurements of 2.0 cm by 1.5 cm by 1.0 cm, and the overall impression of the wound as unchanging. Record review of #8's physician's notes showed on 3/12/24, the pressure ulcer edges were rolled. Record review of resident #8's right buttock pressure ulcer stage and measurements, dated from 3/19/24 to 3/26/24, showed the following: - 3/19/24 A Weekly Pressure Wound Observation Tool - Stage III with measurements of 2.4 cm by 2.5 cm by 3.2 cm. The overall impression of the wound was documented to be worsening. - Record review showed an increase in resident #8's right buttock wound tunneling depth from the first measurements at 2.1 cm by 2.0 cm by 1.6 cm, which was dated on 2/12/24, to measurements of 4.5 cm by 2. 5 cm by 3.7 cm dated on 3/26/24. - Record review of a physician note, dated 3/26/24, showed measurements of the right buttock pressure ulcer as were 4.5 cm by 2.5 cm by 3.7 cm. - A weekly Pressure Wound Observation Tool, dated 3/26/24, showed different measurements of the right buttock pressure ulcer as of 2.5 cm by 2.5 cm by 3.7 cm. Staff member M was documented to be present for both of these skin assessments. During an observation on 3/28/24 at 5:22 p.m., staff member I removed resident #8's wound dressing and stated he was unable to stage the pressure ulcer. When observing the appearance of the wound, the tissue surrounding the wound was light pink in some areas, and slightly white in a small area, around the opening. No slough or excess moisture was observed. The edges were rolled. No muscle, bone or tendon was observed. During an interview on 3/28/24 at 5:33 p.m., NF7 stated in one instance resident #8 had called him at 10:00 p.m., asking him (NF7) for help. The resident said she had been sitting on the bed pan for two hours. Resident #8's pressure ulcer was located on her right buttock. Extra pressure to this location would increase the risk of skin breakdown. 32998 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	3. During an interview on 3/28/24 at 10:53 a.m., staff member M stated she and the wound nurse saw the residents on one unit, each day she was in the facility. Staff member M stated she came to the facility on Tuesday, Wednesday, and Thursday of each week to assess wounds and to update physician orders as needed. Staff member M stated she saw resident #94's wound on the previous day. Staff member M stated nursing staff were to follow the documented provider orders which were in place for the resident's wound care. Staff member M stated the floor nurses were to complete wound care when the NP or wound care nurse were not in the building. Staff member M stated it was the responsibility of nursing to notify the provider of any changes in the appearance of the resident's (or a resident) wound. Staff member M stated a wound sheet was developed and followed when wounds were observed. During an interview on 3/28/24 at 11:35 a.m., staff member M stated resident #94's ear wound was assessed on 3/27/24. Staff member M stated resident #94's left ear wound treatment was to have collagen in the wound bed and a foam barrier on the oxygen tubing (the tubing rubbed the skin). Staff member M stated the wound started as a blister, and had a tegaderm dressing in place. Staff member M stated when the tegaderm was taken off of the wound it was noted the wound was larger than expected. Staff member M stated the resident did not like the cushions on the oxygen tubing, placed for skin pressure relief. Staff member M stated it was expected resident #94's wound would be left open to air for healing. Staff member M stated the wounds were checked weekly and dressings were expected to be dated with the last date wound care was completed. During an observation and interview on 3/28/24 at 4:58 p.m., staff member B stated the pressure ulcer to resident #94's left ear was caused by the oxygen tubing. The pressure injury was located on the curve to the upper ear and was red and scabbed over in some areas. There were red marks and indentations on the left side of the resident's face. Resident #94 stated his ear was sore. Staff member B discussed with resident #94 the importance of keeping his oxygen on, the tubing loose, and the foam pads on the tubing to reduce the pressure on his ears, as to avoid further deterioration. Staff member B stated there were two provider orders in the computer for treatment of resident #94's ear. Staff member B stated those orders needed to be clarified. Staff member B stated the current order was to cover the pressure injury with collagen and leave open to air. Staff member B then removed the tubing and nasal cannula from resident #94's nose and stated the resident needed new tubing. A review of staff member M's physician orders showed on 2/19/24, the implementation of the foam pads to the bilateral ears for the nasal cannula use. The orders included the ears should be kept clean and dry, and the pads should be used for protection daily and at night. Review of resident #94's wound care notes and skin assessments, dated from 3/5/24 to 3/27/24, showed the following: - 3/5/24; Nursing staff instructed to keep foam over NC (nasal cannula) tubing in order to decrease pressure to sites. Under physical exam, documentation showed, Stage 2 ulcers behind bilateral ears-left is open, R is intact blister. The treatments were initiated to avoid further deterioration. A skin at risk assessment related to the residents use of oxygen tubing, and risk of breakdown to his ears from the tubing, was neither not found in the resident's EHR, nor was there documentation showing the wounds were unavoidable. - 3/7/24; Wounds to bilateral ears are noted to be Stage 2-UTA (unable to assess) measurements d/t (due to) location and lack of accuracy . The right ear has an Intact blister, Stage 2-it is non-tender and 100% epithelial tissue with clear fluid underneath. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 3/11/24; Stage 2 pressure ulcers behind bilateral ears-L (left) is open, R (right) is intact blister. - 3/13/24; L ear, posterior stage 3 pressure . This wound measures 0.6 x 0.1 centimeters with a depth of <0.1 centimeters. - 3/20/24; Patient educated on importance of using the foam barriers on his nasal cannula to reduce pressure. Location: R ear, posterior. Type: stage 1 pressure. This wound measures 1.5 x 0.5 centimeters with a depth of <0.1 centimeters. - On 3/20/24, staff member M's progress notes showed upon entering resident #94's room to provide services, it was found the foam barriers for his ears were not in place for skin protection. - 3/20/24; L ear, posterior stage 3 pressure. This wound measures 1.8 x 0.8 centimeters with a depth of <0.1 centimeters. - 3/27/24; Patient educated on importance of using the foam barriers on his nasal cannula to reduce pressure. Location: R ear, posterior. Type: Stage 1 resolved. - 3/27/24; L ear, posterior stage 3 pressure. This wound measures 1.4 x 0.6 centimeters with a depth of 0.1 centimeters. Review of resident #94's wound care notes and skin assessments showed the left ear pressure ulcer went from a Stage II on 3/11/24 to a Stage III on 3/13/24. The facility failed to assess the skin risk related to the resident's ears and oxygen tubing prior to the development of the two blisters.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46400 Based on observation, interview, and record review, the facility failed to secure hazardous areas on the secure unit, which allowed a resident to enter the area(s), which increased the risk of an accident, for a resident who wandered, and the resident had a fall in a janitor's closet, for 1 (#90) of 19 sampled residents on the secure unit. Findings include: During an observation on 3/27/24 at 3:53 p.m., resident #90 was wandering the hallway of the secure unit. He went into the unoccupied resident room, at the far end of the hallway, outside of the visibility of the nurses' station. The room was cluttered, and there were trip hazards including extra furniture and Hoyer lift. The resident was observed to be bending over the mess with the wheelchairs and equipment. Review of resident #90's care plan, with a review date 3/20/23, showed the resident was a high fall risk r/t dementia and poor safety awareness. Review of resident #90's nursing progress notes, dated 2/24/24, showed there was a loud crash which alerted the staff to the resident's fall, which had occurred in the janitor's closet, and the door allowed the resident entry. Review of the facility fall training for staff, not dated, showed nursing was to complete the following tasks after a resident fall: 1. Risk Assessment - all tabs and sign it . 5. Document a New Intervention - We must show that we are protecting the resident from further injury . Review of resident #90's care plan, with a review date 3/20/24, showed a lack of identification for potential risks for the resident and getting into locked or unsafe spaces. Staff were unaware the resident had wandered into a hazardous area, and the accident occurred. During an interview on 3/26/24 at 3:48 p.m., staff member T stated she had not been aware resident #90 had gotten into the janitor's closet on the secured unit. During an interview on 3/27/24 at 3:53 p.m., staff member R stated she had not been aware resident #90 had gotten into the janitor's closet on the secured unit. During an interview on 3/28/24 at 2:45 p.m., staff member D stated the facility investigated the incident with #90 and the fall and assumed the janitor's closet door had been left open. She stated they had since been completing audits on the doors of the secure unit, which were supposed to always be locked.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 32998 Based on observation, interview, and record review, the facility failed to implement sufficient interventions and care plan for a resident with a significant weight loss, for 1 (#94); and failed to ensure residents with limited mobility and who were at risk for dehydration were provided adequate fluids for 2 (#s 35 and 65) of 31 sampled residents. Findings include: 1. During an interview on 3/25/24 at 1:45 p.m., resident #94 stated he did not like the food. The resident stated his food was chopped and mushy. The resident denied having any swallowing difficulties. During an interview on 3/26/24 at 8:41 a.m., resident #94 stated the food was still mushy and did not know why they switched his diet. The resident stated it (diet with different texture) just showed up one day, referring to his food. During an interview on 3/27/24 at 12:40 p.m., staff member I stated the resident's diet order was the closest to the cut up food menu template. Staff member I stated they would need to get a speech evaluation to determine if he was appropriate for a regular diet. During an interview on 3/28/24 at 11:42 a.m., staff member H stated resident #94 had several illnesses over the last few months. Staff member H stated the diet orders came from the admission information. The dietician reviewed the diet orders, and the resident was assessed for food preferences. Review of resident #94's weights showed: - On 2/4/24, the resident weighed 235.6 pounds. - On 3/13/24, the resident weighed 221.6 pounds which is a -5.94 % loss in 38 days. Review of resident #94's progress note, dated 3/15/24, showed a weight warning for a 5% change over 30 days, and a 10% loss over 180 days. Review of resident #94's progress note, dated 3/15/24, showed the resident triggered for significant weight loss for one month, three months, and six months. Review of resident #94's care plan did not show problems, goals, or interventions for nutrition or weight loss since readmission on 2/19/24. 41652 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275026	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 3/26/24 at 7:56 a.m., resident #35 was lying in his bed, on his back, with the head of the bed elevated to approximately 45 degrees. Resident #35's lips were dry and peeling. The resident's bedside table was located on the right side of the bed, parallel to the mattress. The resident was not able to reach either his water pitcher, or a can of root beer, due to the location of the bedside table and the resident's inability to reposition himself. During an observation and interview on 3/27/24 at 7:45 a.m., resident #35's bedside table was still located parallel to the mattress, on the right-hand side of the bed, and was not accessible by the resident. When asked if he was able to reach his fluids when he was thirsty, the resident said he could not reach the fluids, and had to have help to get a drink. The fluids were located on the bedside table. During an interview on 3/27/24 at 7:50 a.m., staff member J stated she tried to provide fluids at least once per hour, and resident #35 sometimes had to yell if he needed help getting a drink. During an interview on 3/27/24 at 10:03 a.m., staff member D stated the need to assist resident #35 with accessing fluids should have been care planned. During an observation and interview on 3/27/24 at 12:16 p.m., staff member O evaluated the position and location of resident #35's bedside table and fluids. Staff member O stated the table needed to be moved so it was in front of resident #35. Staff member O moved the table perpendicular to the resident's mattress, in front of the resident, and across the bed. Staff member O stated resident #35 had limited range of motion in his head and neck, which made it difficult for him to turn his head enough to see the items on the bedside table, when it was placed parallel to the resident's mattress. Review of resident #35's care plan, last revised on 2/10/24, showed the resident was at risk for altered nutrition, and the resident had an ADL self-care deficit. The care plan showed the resident received a diuretic medication, required extensive assistance of two staff for bed mobility, and supervision assist when eating. The care plan failed to show a fluid intake goal or interventions intended to ensure adequate fluid intake. Review of resident #35's fluid intake record, dated from 2/28/24 through 3/27/24, showed the resident's daily intake average was approximately 400 ml per day. According to the Cleveland Clinic, . eight glasses of water per day is a general recommendation .1 Eight glasses of water per day equals 64 ounces, or 1,920 ml of fluids. 1Cleveland Clinic, How Much Water You Should Drink Every Day, 10/13/22, https://health.clevelandclinic.org/how-much-water-do-you-need-daily, accessed on 3/28/24. 3. During an observation on 3/25/24 at 2:45 p.m., resident #65 was lying in bed with the head of the bed elevated to approximately 45 degrees. The resident's bedside table was located on the right side of the bed, parallel to the mattress. The resident was not able to reach his water pitcher due to the resident's limited range of motion and location of the bedside table. Review of resident #65's care plan, dated 2/13/23, showed the resident was at risk for dehydration and was supposed to have fluid intake of at least 1,440 ml per day. (continued on next page)

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Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #65's fluid intake, dated from 2/28/24 to 3/27/24, showed the resident received between 200 and 1,216 ml per day. The average fluid intake was approximately 675 ml per day.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46400 Based on observation, interview, and record review, the facility failed to assess the need for and obtain CPAP supplies for 1 (#6) of 1 sampled resident for respiratory concerns. Findings include: During an interview on 3/27/24 at 3:18 p.m., resident #6 stated she did not have all her belongings at the facility, and her CPAP machine was in her storage unit in [Town Name]. During an observation on 3/27/24 at 4:29 p.m., there was no CPAP machine in resident #6's room. Review of resident #6's Admission Orders, dated 7/18/23, showed, Please provide CPAP supplies. The resident had a diagnosis of Severe Obstructive Sleep Apnea. During an interview on 3/28/24 at 4:06 p.m., staff member H stated resident #6 would be assessed by the provider and specialists for sleep apnea.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on observation, interview, and record review, the facility nursing staff failed to accurately and safely provide pharmaceutical services, use a credible resource for medication identification, and ensure staff utilized the professional nursing standards regarding the six rights of medication administration, which put the resident's at risk for improper use of, or complications related to, medication services. These failures affected 3 (#s 30, 44, and 107) of 44 sampled and supplemental residents. Findings include: During an observation on [DATE] at 8:39 a.m., staff member X searched Google to determine the use and identity of the medication Buspar, which was documented on resident #44's MAR. The medication was located in the package with the other morning medications sent from the pharmacy. Staff member X did not use any current medication resources to identify the medication Buspar. During an observation on [DATE] at 8:39 a.m., staff member X did not wear gloves when handling a lidocaine patch that was out of the package. During an observation and interview on [DATE] at 9:20 a.m., staff member X had been administering diltiazem 120 mg to resident #30. Resident #30's MAR, dated March of 2024, failed to show the dosage of diltiazem to be administered. On the medication packaging from the pharmacy, the diltiazem showed a dose of 120 mg. Staff member X stated, It should have a dose on there . I have been giving it and hoping. Staff member X did not use the six rights of medication administration. During an interview on [DATE] at 11:28 a.m., staff member EE stated if a medication packet (similar to resident #30's diltiazem) did not match the MAR, the nurse should have contacted the pharmacy for a revised order. Staff member EE stated if a medication must be removed and identified from the other medications in the packaging, the nurse should have called the pharmacy or used the pictures at the top of the medication cards as resources. Staff member EE stated it was not acceptable to use Google to identify a medication, as there were reputable pill identifier services available. During an interview on [DATE] at 10:56 a.m., staff member I stated each medication must have a dosage on the MAR, as well as on the medication packaging, which came from the pharmacy. Staff member I stated the top of the medication cards and MAR offered ways to identify a medication as well. Staff member I stated, . myself or [staff member B] will catch these orders. During an observation on [DATE] at 2:14 p.m., staff member Y pre-poured a narcotic medication (Norco 5 mg) for resident #107, and placed the narcotic in an unlabeled medication cup, in the top drawer of the medication cart, rather than in the double locked narcotic drawer, and staff member Y did not label the cup. Record review of the facility's policy Medication Administration, dated [DATE], showed: .10. Ensure that the six rights of medication are followed: a. Right resident (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation . 13. Identify expiration date. If expired, notify nurse manager. 14. Remove medication from source, taking care not to touch medication with bare hand .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 14005 Based on observation, interview, and record review, the facility failed to ensure the daily posting of staffing information was updated daily, accurate, and had all required information for the postings. This practice had the potential to affect anyone wanting to review the posted staffing information. Findings include: During an observation on 3/27/24 at 2:10 p.m., the Daily Posting of Hours of Nurse Staffing sheet, posted near the front door, had postings for five days of the last week. The staff postings for 3/23/24 and 3/24/24 were not available. The posted information sheets did not include the required facility census number, or the changes in staffing hours, when the staffing schedule changed. During an interview on 3/27/24 at 2:12 p.m., staff member W stated she was the person that posted the forms. She stated The staffing job is only a five day a week job and it did not get posted on the weekend. During the interview on 3/27/24 at 2:12 p.m., staff member W said she did not know the staffing form needed to be posted seven days a week, and the census needed to be on the form, or that changes needed to be made when hours changed on the schedule or varied from it. It was found the postings were not timely or accurate, although they were posted with information during the week.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 46400 Based on observation, interview, and record review, the facility failed to ensure staff had adequate training and competencies for newly admitted residents with behavioral health needs, and the deficient practice increased the risk of harm or negative outcome to other residents, staff, visitors, or the resident, when staff were unable to redirect the resident, for 1 (#273) of 44 sampled and supplemental residents. During an interview on 3/27/24 at 11:54 a.m., staff member A stated people heard the facility was admitting psychiatric patients from [Facility Name], and they were scared. Staff member A stated the facility identified a need for more behavioral health training for staff with the new admits with behavioral concerns. During an observation on 3/27/24 at 1:30 p.m., resident #273 was pacing the halls of the secure unit. His posture was tense, his affect was angry, and his fists were clenched. During an interview on 3/27/24 at 3:02 p.m., NF3 stated she had concerns about the appropriateness of resident #273's admission, and concerns for the safety of the other residents on the secure unit, due to #273's aggressive behavior. During an interview on 3/27/24 at 3:53 p.m., staff member R stated staff had dementia training but not behavior or de-escalation training for aggressive residents. Staff member R stated resident #273 had psychotropic medications, but frequently refused them. During an observation on 3/28/24 at 12:23 p.m., resident #273 was pacing the halls and going in and out of other resident rooms at lunchtime. He ignored all staff attempts to redirect him, including one to one visits, offerings of drinks or snacks, showing the resident his table, or showing the resident his room. During an interview on 3/28/24 at 12:56 p.m., NF4 stated there was an occasion where resident #273 had come into the room, sat on the bed, and knocked pictures and decorations off the wall. NF4 asked him to leave, and he became aggressive. NF4, along with the family members of several other residents on the secure unit, were said to be fearful of resident #273 and hurting one of the vulnerable residents who could not defend themselves. Review of resident #273's nursing progress note, dated 12/29/24, showed the resident was pushing and raising his fist at staff while he was trying to exit the secure unit. The note also showed, . Maintenance guys back on the unit trying to fix doors and rsd (resident) did respond well to the men. Would turn around and go back to the dining area without problem. Rsd continued to pace non-stop but stopped trying to get past staff when the men were on the unit . [sic] Review of resident #273's nursing progress note, dated 1/6/24, showed the resident ate his lunch then walked around the dining room taking food from the other residents. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #273's nursing progress note, dated 1/12/24, showed, Rsd (resident) pacing and resistive to cares, taking meds, vitals & weight . did accept meds from male nurse manager . Review of resident #273's nursing progress note, dated 1/30/24 (4:38 p.m.), showed the resident was punching the TV in the common room while several other residents were present and watching TV. After he was redirected from this the nurse was inspecting his hands for injury. He lunged and grabbed both writer's arms and wouldn't let go. He then punched the nurse and TV again before additional staff showed up and were able to redirect him to his room. Review of resident #273's nursing progress note, dated 3/13/24, (5:03 p.m.) showed, . Resident became extremely agitated and grabbed broom that staff was using . it was observed that resident was on floor trying to kick staff . A physician's order was received from the provider for an IM (intramuscular) injection Midazolam. EMS was called to assist facility staff due to the patient's combativeness. Review of resident #273's nursing progress notes, dated 3/19/24 [time 4:36 p.m.], showed the resident had entered another resident's room, and this resident was very angry with the intrusion on his space. Resident #273 was swinging at staff. He jumped onto a bed and attempted to, . rip window off to climb out . EMS was called, and the resident was hospitalized from 3/19/24 - 3/22/24. Review of resident #273's provider note, dated 3/25/24, showed, He has been hospitalized several times in the past several months d/t AMS/agitation. Per staff, patient is combative - he has assaulted multiple staff members (to the point of bruising and having to take time off to recover), uncooperative with unit activities, and disruptive - staff reports that he goes into other patients' rooms and refuses to leave, often time disturbing the other residents. Patient refuses medications frequently as well . [sic] Review of resident #273's nursing progress note, dated 3/28/24, showed, Resident then started going into other residents' room, grabbing their belongings . Went into a female's room and would not exit until and male family member came in and talked to him . [sic] Review of resident #273's care plan, review date 1/13/24, showed under the focus area: The resident has a behavior problem . resulting in risk for physical aggression, endangerment of self/others, refusal of cares and wandering. Resident at times has difficulty being redirected by staff when wandering. Interventions, all dated 1/11/24, included: - Administer medications as ordered . - Anticipate and meet the resident's needs. - Caregivers to provide opportunity for positive interaction . - Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Minimize potential for the resident's disruptive behaviors by offering tasks activities which divert attention such as. - Monitor behavior episodes . - The care plan interventions did not define what needs needed to be anticipated, what positive interactions worked best, how to safely remove him from an area, or what activities to offer for diversion attempts. - There were no updated interventions after the resident had been hospitalized for aggressive behavior. There was no identification that the resident responded better to men. There was no identification the most severe incidents took place in the early evening hours. Review of resident #273's Medication Administration Record, for the month of March 2024, showed several medications prescribed for Dementia, severe, with psychotic disturbance which included: - Seroquel 50 mg TID: there were six refusals out of 54 opportunities, - Hydroxyzine 25 mg TID: with seven doses left blank and three refusals out of 57 opportunities, - Zyprexa 5 mg BID: two refusals of 11 opportunities.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 32998 Based on interview and record review, the facility failed to provide a rationale for continued use of antianxiety medication beyond 14 days for 2 (#s 35 and 81) of 31 sampled residents. Findings include: 1. Review of resident #81's physician order summary, as of 3/27/24, showed an order for clonazepam, 0.5 mg every eight hours, as needed for anxiety. The medication start date was 2/22/24. Review of resident #81's Medication Administration Record showed the resident took 0.5 mg clonazepam five times between 3/1/24 to 3/27/24. Review of resident #81's Psychotropic & Sedative/Hypnotic Utilization, dated 2/1/24 to 2/29/24, showed the resident had clonazepam 0.5 mg every eight hours as needed. During an interview on 3/28/24 at 2:42 p.m., staff member H stated there was no documented rationale for the continued use of clonazepam. 41652 2. Review of resident #35's MAR, dated March of 2024, showed a medication order for lorazepam, 0.5 mg every two hours, as needed for anxiety, agitation, or air hunger. The lorazepam order was dated 2/9/24. During an interview on 3/28/24 at 8:39 a.m., staff member B stated she was not aware as needed psychotropic medications ordered by hospice needed to be limited to 14 days. Staff member B stated she reached out to resident #35's provider regarding the rationale for continued use of the as needed lorazepam. Review of resident #35's nursing progress note, dated 3/27/24, showed staff member B contacted the provider regarding the 14 day limit for as needed psychotropic medications. The note also showed a new order was placed for as needed lorazepam with a 14 day limit. Review of the facility's policy titled Use of Psychotropic Medication, dated November of 2023, showed orders for as needed psychotropic drugs were limited to 14 days. If the provider believed the medication was appropriate beyond 14 days, the provider needed to document the rationale in the resident's medical record. A request was made on 3/26/24 for the provider documentation of the rationale for continuing the as needed lorazepam for #35. No documentation for resident #35 was received prior to the end of the survey.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50245 Based on observation, interview, and record review, the facility failed to ensure food was served at a palatable temperature, and not appetizing, failed to ensure dishes were clean and in good repair, and that altered food diets were not served in an appealing manner for all residents who received meals from the facility, and this was found to have affected 4 (#s 59, 76, 113, and 278) of 44 sampled and supplemental residents. Findings include: During an interview on 3/25/24 at 1:26 p.m., resident #113, stated, when the surveyor asked about the food temperature, Hot food is lukewarm meaning the food was served lukewarm rather than hot, per the resident's perception. During an interview on 3/25/24 at 3:39 p.m., resident #59 stated the food is hardly ever hot enough for the resident's liking. During an interview on 3/26/24 at 9:45 a.m., resident #278 stated the breakfast cart comes to their wing at 7:10 a.m., but resident #278 does not receive her food until 7:45 a.m. Resident #278 stated, (For breakfast) oatmeal is served several days a week. It's always cold and just a big blob. Resident #278 stated the day prior, her orange juice glass had been cracked and leaking on her tray. Resident #278 stated the drinking glasses often have residue on the inside that can be scraped off. She said, There is so much with food service (with the food that is served) that has to be appealing to the eye. Resident #278 stated the facility no longer brings juice because they do not have lids to cover the juice during transport in the cart, so they do not always offer juice. Resident #278 stated, I have doctors orders for my food to be cut up, but I don't need my biscuit to be pulverized. Same with my orange. It does not need to be squished for me. This resident also expressed concern for losing weight and had outside food brought in for her. Record review of resident #278's EMR showed she was to have a Regular diet, Soft and Bite-Sized texture, Regular/Thin consistency liquids. Record review of resident #278's EMR showed resident #278's first weight in the facility to be 149.2 pounds on 3/19/24. Resident #278's most recent weight on 3/25/24 was 143.6 pounds, reflecting a loss. During an observation on 3/28/24 at 2:05 p.m., resident #76 had a lunch tray that consisted of two pureed foods sitting in the middle of the plate, both unidentifiable, approximately one cup of peach colored juice, and a small container of pudding. Resident #76 stated the food did not taste very good. Record review of resident #76's EMR diet order showed the food was to be Minced and Moist, not pureed.

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652 Based on interview and record review, the facility failed to ensure hospice services were communicated to direct care staff, to include the receipt and use of the hospice care plan and visit notes, for 1 (#35) of 2 sampled residents receiving hospice services. Findings include: Review of resident #35's hospice orders, dated 2/6/24, showed the resident was admitted to hospice that day. During an interview on 3/26/24 at 8:02 a.m., resident #35 stated he did not know why he was receiving hospice services. During an interview on 3/28/24 at 8:15 a.m., staff member K stated the only communication with hospice staff she was aware of, was on the day they (hospice staff) visited resident #35. Staff member K stated she was not aware of any documentation from hospice being in the resident's EMR. Review of resident #35's facility care plan, dated 2/10/24, showed the resident was receiving hospice services, but the care plan failed to show what services were being provided through hospice or the need to communicate and document the resident's response or use of the hospice care plan. Review of the facility's policy titled, Coordination of Hospice Services, not dated, showed the facility was responsible for maintaining communication with hospice, monitoring, and evaluating the resident's response to the hospice care plan. Review of the facility's [NAME] with the hospice provider, dated 4/27/20, showed, . B. SERVICES TO BE PROVIDED BY HOSPICE . Promptly upon consent of the Residential Hospice Patient (or his/her legal representative), Hospice shall furnish Nursing Facility with a copy of the Hospice Plan of Care . A request was made on 3/26/24 for resident #35's hospice care plan and encounter notes. The documents were provided on 3/27/24, and showed they were faxed to the facility on [DATE] at 2:16 p.m. The documents were not present in the resident's EMR from his admission to hospice (2/6/24) until the start of the survey, which was on 3/25/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275026	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Great Falls	1130 17th Ave S Great Falls, MT 59405

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 14005 Based on observations and interviews, the facility staff failed to maintain infection control parameters for N95 mask use during a COVID-19 outbreak, and deliver resident meals in a safe manner, which had the potential to affect all residents receiving meals or coming into contact, either direct or indirect, with staff not using PPE properly; and ensure one resident was free from drinking potentially contaminated drinks, for 1 (#26); and staff failed to perform hand hygiene and glove changes when moving from a dirty task to a clean task, for 1 (#65) of 31 sampled residents. Findings include: 1. During an observation on 3/25/24 at 12:05 p.m., the facility was in the process of managing a Covid outbreak, and staff member AA and BB were observed with their mask down under their noses, worn improperly. Staff member Z and BB were talking, and both staff pulled their masks down with their hands, and replaced their masks. Without hand sanitization, the staff continued to place food items on the resident meal trays, and then place the trays into the cart. Staff member CC stated they probably pulled their masks down due to the difficulty communicating with masks on. Staff member CC verified staff should have washed their hands prior to continuing with food service. 2. During observation on 3/25/24 at 1:30 p.m., resident #26's refrigerator contained eight glasses of uncovered drinks. The resident said she leaves the drinks in the refrigerator until they taste sour, then she throws them away. During an observation on 3/28/24 at 5:10 p.m., resident #26's refrigerator had six partially filled glasses of uncovered and unlabeled drinks. She could not remember when the drinks were put in the refrigerator. 3. During an observation of meal service on 3/26/24 at 12:51 p.m., staff were delivering trays to the residents residing in the rooms on that hall. Eight trays were observed to be carried down the hallway, without drink covers. 41652 4. During an observation on 3/25/24 at 2:54 p.m., staff members P and U were assisting with incontinence care for resident #65. After cleaning the resident and removing the soiled attend, staff member P failed to remove his dirty gloves, perform hand hygiene, and put on new gloves. Staff member P, with dirty gloves, placed a clean attend on the resident, placed the resident on the Hoyer sling, then operated the Hoyer lift to transfer the resident from his bed, to his power wheelchair. Staff member P removed the lift from the room and returned to the resident's room before removing his dirty gloves and performing hand hygiene. During an interview on 3/27/24 at 9:00 a.m., staff member D stated staff had been trained to change gloves and perform hand hygiene when they went from a dirty task to a clean task.