STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275030	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Transitional Care and Rehabilitation	1500 32nd St 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 47752 Based on observation, interview, and record review, the facility failed to provide dignity and respect to 1 (#1) of 4 sampled residents. This deficient practice caused the resident to feel embarrassed and humiliated. During an interview on 3/27/24 at 8:42 a.m., NF1 stated she had cared for resident #1 during a follow up appointment at a local physician's office on 2/29/24. NF1 stated resident #1 came to her appointment soiled with urine and dried stool. NF1 stated she had to help resident take her pants off, so the provider could look at the surgical incision on her left knee. NR1 stated resident #1's incontinent brief was saturated and had leaked on to her clothing and wheelchair. NF1 stated she had left the room to retrieve supplies so she could clean her up. NF1 stated when she returned to the room and took off the soiled incontinent brief, she had found dried stool on her buttocks. NF1 stated resident #1 had told her she had not been toileted or changed all day. NF1 stated after she had cleaned up resident #1, she placed a pair of dry shorts that she found at the physician's office on resident #1. NF1 stated that resident #1 and NF3 apologized to her and verbalized how embarrassed they were. NF1 stated she had placed the soiled pants in a bag and sent them back to the facility with resident #1 and NF3. During an observation, and interview, on 3/27/24 at 10:10 a.m., resident #1 was sitting in a wheelchair with a knee brace in place. Resident #1's room had a very strong urine smell. Resident #1 stated she had occasional bowel and bladder incontinence and required assistance from staff with toileting occasionally. Resident #1 stated she had been living independently prior to her admission. Resident #1 stated she was now able to take herself to the bathroom, which had cut down on me having an accident, Resident #1 stated when she first was admitted to the facility, she could not put any weight on her left leg because she had broken her knee. Resident #1 stated, I was so embarrassed when I went to my appointment. I was soaking wet. Nobody helped me before I left. It was humiliating. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/24 at 10:15 a.m., NF3 stated resident number had problems with bowel and bladder incontinence, and it had gotten worse after she had knee surgery. NF3 stated when resident #1 was admitted to the facility she had been non-weight bearing on her left leg and required the use of an immobilizer. NF3 stated resident #1 needed assistance with dressing, toileting, and bathing. NF3 stated resident #1 is starting to do more tasks independently. NF3 stated resident #1 can now put weight on the left leg as long as she had the knee brace in place. This has helped with the incontinence since she is able to take herself to the bathroom. NF3 recalled the follow up appointment for resident #1's knee. NF3 stated, Normally when resident #1 has an appointment I go to the facility and help her get ready. That day I had just met her at the doctor's office. When the staff member removed the blanket that was across resident #1's lap, her pants were soaking wet with urine. Resident #1 told me that she had not be toileted or changed all day. Both resident #1 and I were humiliated and embarrassed. I was mortified for the both of us. How was her right to be treated with dignity protected. That was not dignity. I did file a grievance with the facility's social worker. During an interview on 3/27/24 at 12:33 p.m., staff member H stated she had received a grievance from NF3 about the incident that occurred at resident #1's follow up appointment. Staff member H stated after she received the grievance, she had interviewed facility staff. Staff member H stated the staff that she had interviewed denied that resident #1 was soiled prior to her appointment. Staff member H stated she had followed up with NF3 and NF3 was fine with the outcome. A review of a facility document titled, Grievance Form, dated 3/1/24, showed NF3 filed a grievance with social services. On the grievance form under, Review Finding: Resident #1 is continent of bowel and bladder and can verbalize when the bathroom is needed. Staff claim resident #1 was not sent out messy .This seems to be a case of an accident. A Review of resident #1's electronic medical record, dated 2/27/24 to 3/27/24, showed: Resident #1 had been incontinent 37 times. A review of a facility document titled, Incontinence, dated 10/23/23 showed: Policy: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. . 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. A review of a facility policy titled, Resident Rights, with a handwritten date of 11/18/23, showed: . Resident rights. The resident has the right to a dignified existence . 4. Respect and Dignity. The resident has a right to be treated with respect and dignity .

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47752 Based on observation, interview, and record review, the facility failed to complete a thorough investigation to include root cause analysis for a fall with injury for 1(#9) of 3 sampled residents. This deficient practice had the potential to affect all residents that are at risk for falls. Findings include: During an observation and interview on 3/28/24 at 8:30 a.m., resident #9 was lying in bed watching TV. Resident #9 stated he remembered the fall but could not remember why he fell . Resident #9 stated he was sent to the hospital after the fall but is doing fine now. During an interview on 3/28/24 at 8:35 a.m., staff member K stated resident #9 had a fall earlier this month that resulted in a fractured hip. Staff member K stated resident was sent to the emergency room for an increased complaint of pain to his left hip. During an interview on 3/38/24 at 3:00 p.m., staff members A and B did not know what caused the fall and could not verbalize any root cause analysis. During an observation on 3/28/24 at 4:00 p.m., resident was lying in bed with his eyes closed. Resident #9 asked to be left alone because he wanted to rest. During an interview on 4:04 p.m., Staff member K stated when resident #9 fell he was close to the bathroom. Staff member J stated, Resident #9 has moments of clarity and thinks he can still walk and do basic tasks even though he has left sided weakness from a stroke. I am pretty sure that resident #9 fell because he was trying to walk to the bathroom. Review of a Facility Reported Incident, submitted to the State Survey Agency on 3/10/24, showed: Resident had an unwitnessed fall in his room .He was later sent to the ER due to increased pain in left hip . investigation started. Findings were submitted to the State Survey Agency on 3/14/24, showed: The resident was sent out via Great Falls EMS .x-ray done of left hip and showed a fracture. The resident has a trochanteric fixation nailing of his left hip Investigation closed. No root cause analysis was conducted to help determine the cause of the fall or what interventions the facility would implement to try and keep resident #9 safe and free from falls. A review of a facility policy titled, Incidents and Accidents, with an implementation date of 11/28/23, showed: .Policy explanation: . -Assuring that appropriate and immediate interventions are implemented, and corrective actions are taken to prevent recurrences and improve the management of resident care. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. -Meeting regulatory requirements for analysis and reporting of incidents and accidents.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47752 Based on observation, interview, and record review, the facility failed to complete an accurate MDS assessment in the area of bowel and bladder in accordance with the RAI requirements for 1 (#1) of 4 sampled residents. Findings include: During an observation, and interview on 3/27/24 at 10:10 a.m., resident #1 was sitting in a wheelchair with a knee brace in place. Resident #1's room had a very strong urine smell. Resident #1 stated she had problems at times with bowel and bladder incontinence. Resident #1 stated now that she can put weight on her left leg, she could take herself to the bathroom when she needed to. During an interview on 3/27/24 at 10:15 a.m., NF3 come to visit resident #1. NF3 stated resident number had problems with bowel and bladder incontinence, and it had gotten worse after she had knee surgery. During an interview on 3/27/24 at 2:04 p.m., staff member I stated resident #1 was continent of bowel and bladder. During an interview on 3/27/24 at 2: 16 p.m., staff member J stated she did not normally work on the unit and was not familiar with resident #1. Staff member J stated she was told that resident #1 was continent of bowl and bladder. Review of resident #1's MDS, with an ARD of 2/22/24, showed: In section H, bladder and bowel, resident #1 was always continent of bladder and bowel and was not on a toileting schedule or program. During an interview on 3/28/24 at 11:03 a.m., staff member D stated she was the case manager and was currently doing all the facility's MDS assessments. Staff member D stated when a resident is admitted the nurse on shift will typically start the admission assessments. Staff member D stated she used a work sheet that she fills out when it is time to do the MDS. Staff member D stated there was not a specific MDS policy, they used the timeframes and guidelines set for the in the RAI manual. Staff member D stated she did not do resident #1's MDS. Staff member D stated she had been out of town and at that time they had another MDS nurse to help her. Staff member D stated when doing the MDS, CNA documentation, and nursing documentation are looked at and then documented on the MDS. Review of resident #1's electronic medical record, dated 2/27/24 to 3/27/24, showed: Resident #1 had been incontinent 37 times. A review of a facility document titled, Incontinence, dated 10/23/23 showed: Policy: Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. . 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the RAI Manual 3.0 version, Section H showed: Steps for Assessment 1. Examine the resident to note the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records .

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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 47752 Based on observation, interview, and record review, the facility failed to implement a baseline care plan, outlining pertinent information needed to care for a new resident within 48 hours of admission for 1(#1) of 4 sampled residents. This deficient practice had the ability of affect all new admissions receiving care in the facility. Findings include: During an observation, and interview on 3/27/24 at 10:10 a.m., resident #1 was sitting in a wheelchair with a knee brace in place. Resident #1's room had a very strong urine smell. Resident #1 stated she had occasional bowel and bladder incontinence. During an interview on 3/27/24 at 10:15 a.m., NF3 stated resident number had problems with bowel and bladder incontinence, and it had gotten worse after she had knee surgery. NF3 stated when resident #1 was admitted to the facility she had been non-weight bearing on her left leg and required the use of an immobilizer. NF3 stated resident #1 needed assistance with dressing, toileting, and bathing. During an interview on 3/27/24 at 2:04 p.m., staff member I stated resident #1 had been admitted due to a fracture. Staff member I stated she had been non-weight bearing when she first arrive but is now weight bearing as tolerated. Staff member I stated resident #1 was continent of bowel and bladder but needed assistance with some of her activities of daily living. During an interview on 3/27/24 at 2:16 p.m., staff member J stated she did not usually work on this unit. She stated that she does not know much about any of the residents, and what she did know what told to her in report. Staff member J stated that she was told resident #1 needed assistance with dressing and personal hygiene but was continent of bowel and bladder. Staff member J could not verbalize where she could look to find information on residents. Staff member J was not sure how to access a resident's care plan. Staff member J stated if she had questions, she would ask the nurse. Review of resident #1's electronic baseline care plan, dated 2/20/24, showed the assessment was created on 2/20/24 and was not completed and locked until 3/5/24, 14 days after admission. The baseline care plan did not address resident #1's transfer status, weight bearing status, or information relating to activities of daily living. Review of a facility policy titled, Baseline Care Plan, with a handwritten date of 10/27/23, showed: . Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed with in 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47752 Based on observation, interview, and record review, the facility failed to complete a comprehensive, person-centered care plan for 1 (#1) of 4 sampled residents. This deficient practice did not address the proper care needs for the resident. Findings include: During an observation, and interview on 3/27/24 at 10:10 a.m., resident #1 was sitting in a wheelchair with a knee brace in place. Resident #1's room had a very strong urine smell. Resident #1 stated she had occasional bowel and bladder incontinence and occasionally required assistance from staff with toileting, dressing, and bathing. Resident #1 stated she could brush her own hair and teeth. Resident #1 stated she had been living independently prior to her admission. Resident #1 stated she was now able to take herself to the bathroom, which has cut down on me having an accident, Resident #1 stated when she first was admitted to the facility, she could not put any weight on her left leg because she had broken her knee. During an interview on 3/27/24 at 10:15 a.m., NF3 stated resident #1 had problems with bowel and bladder incontinence, and it had gotten worse after she had knee surgery. NF3 stated when resident #1 was admitted to the facility she had been non-weight bearing on her left leg and required the use of an immobilizer. NF3 stated resident #1 needed assistance with dressing, toileting, and bathing. NF3 stated resident #1 is starting to do more tasks independently. NF3 stated resident #1 could now put weight on the left leg as long as she had the knee brace in place. This had helped with the incontinence since she was able to take herself to the bathroom. During an interview on 3/27/24 at 2:04 p.m., staff member I stated resident #1 had been admitted due to a fracture. Staff member I stated she had been non-weight bearing when she first arrive but is now weight bearing as tolerated. Staff member I stated resident #1 was continent of bowel and bladder but needed assistance with some of her activities of daily living. Staff member I stated that resident #1 is expected to be in the facility short term and her plan is to discharge to an assisted living facility. Staff member I stated she did not have a role in the care planning process. During an interview on 3/27/24 at 2:16 p.m., staff member J stated she did not usually work on this unit. She stated that she does not know much about any of the residents, and what she did know what told to her in report. Staff member J stated that she was told resident #1 needed assistance with dressing and personal hygiene but was continent of bowel and bladder. Staff member J could not verbalize where she could look to find information on residents. Staff member J was not sure how to access a resident's care plan. Staff member J stated if she had questions, she would ask the nurse. Review of resident #1's electronic comprehensive care plan, dated February 2024, showed: No focus, goals, or interventions related to activities of daily living, bowel and bladder status, transfer status, weight bearing status, or services provided by physical therapy. A review of a facility document titled, Comprehensive Care Plans, with a handwritten date of 11/23/23, showed: . 3. The comprehensive care plan will describe at minimum, the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. f. Resident specific interventions that reflect the resident's needs and preferences . 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs .The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.