

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Park Place Transitional Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<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>14005</p> <p>Based on interview and record review, the facility failed to identify a resident's elopement risk and update the care plan with interventions to prevent elopement for 1 (#16) of 4 residents sampled for elopement. Findings include:</p> <p>Review of resident #16's nurse progress notes, dated 10/9/24, showed .she found the resident wandering out of the facility .</p> <p>Review of resident #16's BIMs (Brief Interview for Mental Status) assessment, dated 10/17/24, showed resident #16 scored a 3 which showed the resident had severe cognitive impairment.</p> <p>During an interview on 11/5/24 at 4:33 p.m., staff member A said resident #16 would routinely sit near the doors. Staff member A said she did not identify when resident #16 was wandering outside the facility on 10/9/24 as an elopement.</p> <p>During an interview on 11/6/24 at 7:45 a.m., staff member B said resident #16 would go outside only with her family, but not by herself.</p> <p>During an interview on 11/6/24 at 8:00 a.m., staff member D said she was not aware resident #16 ever sat near the front doors or sat outside by herself.</p> <p>During an interview on 11/6/24 at 8:23 a.m., staff member C said she always worked the 400 hallway and knew resident #16's habits. Staff member C said the resident either stayed in her room, visited with a friend across the hall, or sat in the common TV area, but did not leave the unit. Staff member C said she was not aware resident #16 ever sat near the front doors or sat outside. Staff member C said she was told resident #16 was outside on 10/9/24 wandering and looking for her husband. Staff member C said a wanderguard (alert bracelet) was placed on resident #16 when she returned after the elopement.</p> <p>Resident #16's care plan was not updated timely after the elopement, and occurred on 10/22/24, which was when interventions were added to prevent further elopements.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>14005</p> <p>Based on interview and record review, the facility failed to identify a resident's elopement risk, implement effective interventions to prevent elopement, and failed to follow facility policy, for 2 (#16 and #23) of 4 residents sampled for elopements. Findings include:</p> <p>1. Review of resident #23's nurses notes dated 4/26/23, showed the resident eloped from the nursing home and was found one mile away from the facility. The facility revised the care plan and showed the staff would have their eyes on him every hour.</p> <p>Review of resident #24's elopement assessment, dated 10/16/24, showed the resident had an elopement risk score of 11, which showed he was at high risk for elopement.</p> <p>Review of resident #23's E-interact form, dated 10/20/24, showed resident #23 was able to ambulate without assistance. The e-interact form showed resident #23 eloped from the facility at 6:31 a.m. that day.</p> <p>Review of the facility incident report, for #23's elopement, dated 10/20/24, showed the resident was last seen at 3:00 a.m., and the resident was not in his room at 4:15 a.m. The facility event form dated 10/20/24, showed resident #23's sister, the hospitals, the police, and management staff were notified of the elopement at 5:00 a.m.</p> <p>Review of resident #23's nursing notes, dated 10/20/24, showed the police department notified the facility the resident was found at 2:45 p.m. on 10/20/24.</p> <p>During an interview on 11/5/24 at 4:33 p.m., staff member A said resident #23 was gone from the building for well over seven hours. The resident was found by the police department in an alley on the other side of tenth avenue, which was a minimum of five blocks away. Staff member A was not able to give an exact location where resident #23 was found, as the facility had not obtained the police report.</p> <p>Review of resident #23's treatment record for October 2024, showed the facility failed to monitor the resident's placement every hour as directed by the active care plan. The facility also did not monitor placement of the wander guard bracelet or function of the bracelet, until after the resident eloped on 10/20/24.</p> <p>2. Review of resident #16's nursing progress notes, dated 10/9/24, showed, . She found the resident wandering out of the facility . and the nursing notes did not show the legal representative, and the attending physician, had been notified. The nursing note did not show the resident had been re-assessed upon coming back to the facility.</p> <p>Review of the facility elopement policy from MED PASS Incorporated, with a revision date of 12, 2007, showed the staff were to examine the resident upon return to the facility. The policy also showed the legal representative, and the physician, would be notified upon the return of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #16's BIMs assessment, dated 10/17/24 showed resident #16 scored a 3 which reflected the resident had severe cognitive impairment.</p> <p>During an interview on 11/5/24 at 4:33 p.m., staff member A said resident #16 would routinely sit near the doors. Staff member A said she did not identify when the severely cognitively impaired resident got outside and was wandering as an elopement.</p> <p>During an interview on 11/6/24 at 7:45 a.m., staff member B said resident #16 would only go outside with her family and not by herself.</p> <p>During an interview on 11/6/24 at 8:00 a.m., staff member D said she was not aware resident #16 ever sat near the front doors or outside.</p> <p>During an interview on 11/6/24 at 8:23 a.m., staff member C said she always works the 400 hallway and knew resident #16's habits. Staff member C said the resident either stayed in her room, visited a friend across the hall or sat in the common TV area but did not leave the unit. Staff member C said she was not aware resident #16 ever sat near the front doors. Staff member C said she was informed resident #16 was outside on 10/9/24 wandering and looking for her husband. Staff member C said a wander guard was placed on resident #16 when she returned after the elopement.</p> <p>Review of resident #16's nursing elopement evaluation dated 10/22/24 showed resident #16 did not have a history of eloping from the nursing home. Resident #16's care plan was not updated until 10/22/24 when interventions were added to prevent further elopement.</p> <p>Review of a policy written by MED PASS Incorporated titled Elopements with a revision date of 12/2007, showed:</p> <p>. 3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall:</p> <ol style="list-style-type: none"> a. Examine the resident for injuries; b. Notify the Attending Physician; c. Notify the resident's legal representative (sponsor) of the incident .