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	04/25/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46400 Based on interview and record review, the facility failed to continuously assess and document on a penile ulcer that was progressively worsening for 1 (#40) of 1 resident sampled for wound concerns. Findings include: Review of resident #40's nursing admission assessment, dated 3/5/24, showed skin concerns to the groin, Moisture/excoriation to head of penis with some dark discoloration at frenulum. Review of resident #40's hospital discharge summary, dated 3/15/24, showed progression to a penile ulcer and recommendations for wound care. Review of resident #40's hospital discharge summary, dated 4/11/24, showed, .this lesion appears to be 'dry gangrene' although there is malodor. This is likely complicated by the fact the patient is incontinent of urine . aggressive treatment is recommended in the event of gangrene progression, to include a total or partial penectomy . The ulcer was determined to be caused by calcifying uremic arteriolopathy (calciphylaxis) a disease of high mortality associated with end stage renal disease. Review of resident #40's skin assessments, dated March 2024 - April 9, 2024, requested on 4/24/24 at 8:40 a.m., showed no nursing evaluations of the penile excoriation/ulcer outside of the initial 3/5/24 admission assessment. Review of the facility policy, Perineal Care, dated 2/4/24, showed, .19. Always note any skin changes such as rash, red or pink areas or any discolorations to skin. Report to nurse when applicable. Review of resident #40's nursing progress notes, from 3/5/24 to 4/9/24, failed to show any documentation on the resident's penile ulcer or its worsening status. Review of resident #40's care plan, with an initiation date of 4/4/24, showed the following focus areas: - I have actual impairment to skin integrity of the glans/penis r/t ischemic injury r/t self pleasure. During an interview on 4/24/24 at 12:00 p.m., staff member G stated resident #40 had been admitted with several wounds. Staff member G stated all the wound care they had been applying to the penile wound was being wiped off by the resident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/24 at 8:23 a.m., staff member B stated resident #40 would not stop touching himself and that had made the wound care difficult.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400 Based on observation, interview, and record review, the facility failed to identify a discrepancy in weight recordings which would have identified a severe 16% weight loss in two weeks, for 1 (#40) of 1 dialysis resident sampled for weight loss. Findings include: Review of resident #40's Dialysis Communication Records, dated 3/18/24 - 4/3/24, showed an average of 2. 06 lbs. of fluid removal at each dialysis treatment. The resident never had body or fluid weight gain between dialysis treatments, instead each pre-dialysis treatment record showed a consistently downward trending weight loss of one to four pounds. This loss of body weight represented a severe 16.27% weight loss in two weeks: - 3/18/24 pre-dialysis weight 205.48 lbs. Post dialysis weight was 200.6 lbs. The treatment resulted in 4.88 lbs. of fluid removal. - 3/20/24 pre-dialysis weight was 200.6 lbs. The resident had not gained any weight between treatments. Post dialysis weight was 199.54 lbs. The treatment resulted in 1.06 lbs. of fluid removal. - 3/22/24 pre-dialysis weight was 196.9 lbs. The resident had lost 2.64 lbs. between treatments. Post dialysis weight was 196.9 lbs. The treatment did not perform any fluid removal. - 3/25/24 pre-dialysis weight was 195.14 lbs. The resident had lost 1.76 lbs. between treatments. Post dialysis weight was 192.94 lbs. The treatment resulted in 2.2 lbs. of fluid removal. - 3/27/24 pre-dialysis weight was 191.62 lbs. The resident had lost 1.28 lbs. between treatments. Post dialysis weight was 189.64 lbs. The treatment resulted in 1.98 lbs. of fluid removal. - 3/29/24 pre-dialysis weight was 185.02 lbs. The resident had lost 4.62 lbs. between treatments. Post dialysis weight was 182.6 lbs. The treatment resulted in 2.42 lbs. of fluid removal. - 4/1/24 pre-dialysis weight was 179.08 lbs. The resident had lost 3.52 lbs. between treatments. Post dialysis weight was 177.32 lbs. The treatment resulted in 1.76 lbs. of fluid removal. - 4/3/24 pre-dialysis weight was 172.04 lbs. The resident had lost 5.28 lbs. between treatments. Post dialysis weight was 169.84 lbs. The treatment resulted in 2.2 lbs. of fluid removal. Review of resident #40's weekly weight summary in PCC showed: - 3/15/24 - 201.74 lbs. via wheelchair scale, - 3/22/24 - 196.9 lbs. via wheelchair scale, - 3/31/24 - 193.8 lbs. via mechanical lift scale. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility's weight of 193.8 lbs., on 3/31/24, was 8.78 lbs. over the dialysis weight of 185.02 lbs. and two days prior on 3/29/24, and 14.72 lbs. heavier than the dialysis weight of 179.08 lbs. one day later on 4/1/24. The facility weight was the weight used at the IDT weight meeting, dated 4/5/24, that did not identify the resident as having a weight loss. During an interview on 4/25/24 at 8:46 a.m., staff member M stated resident weights were monitored by the electronic health record dashboard or if nursing brought up concerns to her. The dashboard showed weights entered as seen on the vitals page in PCC. Staff member M stated when she saw resident #40 on 4/7/24, she had observed muscle and fat loss and initiated a weight loss warning. The weight loss was later deemed unavoidable as the resident had been hospitalized [DATE] and transitioned to comfort care for other comorbidities. During an observation and interview on 4/25/24 at 9:09 a.m., staff member I stated to weigh a resident with the mechanical lift scale you would first zero it out, and then lift the resident to be weighed. Staff member I performed the zero task (adjusting scale to a weight of zero) and then raised a resident out of bed. The scale showed the resident as weighing 11.5 lbs. staff member I stated that was not correct, and she didn't know why the scale wasn't working. During an interview on 4/25/24 at 9:45 a.m., staff member A stated maintenance had a schedule where the scales would be calibrated.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400 Based on interview and record review, the facility failed to ensure a resident was free from a medication error ommission, for 1 (#244) of 4 sampled residents. This deficient practice caused a resident to miss 15 days of two medications, which had been prescribed to improve urine flow, and assist in the resident's catheter removal. Findings include: Review of resident #244's physician progress note, dated 4/9/24, showed the resident had a urinary catheter placed due to urinary retention, while in the hospital. Per the physician note, the plan was for the resident to continue taking Flomax and start Finasteride before his follow up with urology scheduled in May 2024. Review of resident #244's MAR, dated April 2024, showed the resident was not taking Finasteride. The resident's Flomax had been discontinued on April 10, 2024. During an interview on 4/24/24 at 10:00 a.m., resident #244 stated he was scheduled to have his catheter removed in May, and he was anxious to get it done. During an interview on 4/24/24 at 10:56 a.m., staff member F stated resident #244 was supposed to be on those medications (Flomax and Finasteride) specifically for his upcoming void trial with urology. Staff member F stated the physician orders must have gotten messed up, and they would be restarted. Reference: According to an article in the National Library of Medicine titled, Tamsulosin in the management of patients in acute urinary retention from benign prostatic hyperplasia, Men catheterized for AUR (acute urinary retention) can void more successfully after catheter removal if treated with tamsulosin, and are less likely to need re-catheterization. [NAME], Department of Urology, Mount [NAME] Hospital, Modern best practice in the management of benign prostatic hyperplasia in the elderly, Published online 2020 May 27, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7273551/.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47785 Based on observation, interview, and record review, the facility staff failed to use standard precautions while doing laundry, resulting in the potential for cross contamination, which could negatively affect anyone coming into contact with the staff who provided laundry service. Findings include: During an observation on 4/24/24 at 2:20 p.m., it was noted there were no protective gowns or gloves available to be worn by staff while handling soiled laundry, in the dirty linen area, of the laundry room. During an interview on 4/24/24 at 2:23 p.m., staff member K stated, We just throw it (soiled laundry) in (to the washing machine). We don't have any covers (personal protective equipment). As the surveyor and staff member exited the laundry room, staff member J asked if she should educate the laundry staff on wearing clothing covers and gloves while handling soiled linens. Review of the facility policy titled, Handling Soiled Linen, last reviewed on 1/8/24, showed, .2. All used linen should be handled using standard precautions (i.e., gloves) and treated as potentially contaminated. Other protective equipment may be required . 3. Linen should not be allowed to touch the uniform or floor . References: Review of an article on the Center for Disease Control website titled, Appendix D - Linen and laundry management, Best Practices for Environmental Cleaning in Global Healthcare Facilities with Limited Resources, last Reviewed: May 4, 2023 showed: Best practices for personal protective equipment (PPE) for laundry staff: - Practice hand hygiene before application and after removal of PPE. - Wear tear-resistant reusable rubber gloves when handling and laundering soiled linens. - If there is risk of splashing, for example, if laundry is washed by hand, laundry staff should always wear gowns or aprons and face protection (e.g., face shield, goggles) when laundering soiled linens. Source: Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Healthcare Quality Promotion (DHQP), https://www.cdc.gov/ncezid/dhqp/index.html.