STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275043	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health & Rehabilitation	2651 South Ave W Missoula, MT 59804

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observation and interview, the facility failed to provide clean resident rooms for 3 (#s 72, 16 and 95) of 28 sampled residents, and failed to provide clean hallways, which had the potential to affect all staff and visitors. Findings include: During an observation and interview on 11/19/24 at 3:12 p.m., resident #72 said she did not know when the last time her floor had been mopped. Resident #72 said she knows she was not always in her room, but the same sticky substance had been on her floor for several days. Resident #72 said she did not like her room and the floor being dirty. The observation made of resident #72s room showed, a plastic knife, a pen, and three clear plastic wrappers were under the bed. Resident #72's floor was observed to have a red sticky substance in the middle of her floor beneath her overbed table. A [NAME] brown sticky substance was also observed under the edge of her nightstand. The substance looked like it had leaked onto the floor spread out onto the floor. During an interview on 11/19/24 at 3:27 p.m. resident #16 and NF2 said the housekeepers only sweep and mop once a week or so and it was dirty yesterday and was still dirty today. NF2 pointed out several dark spots on the floor. NF2 said those spots had been there for several days. During an observation made on 11/20/24 at 10:00 a.m., resident #72 had a plastic knife, a pen and three clear plastic wrappers under her bed. A red colored sticky substance was on the floor in the center of the room. The nightstand was observed to have a reddish-brown stick substance under the front right edge and smeared out and onto the floor. During an observation on 11/21/24 at 7:30 a.m., resident #72 did not have any garbage under the bed. Resident #72's floor looked unchanged as it had a red sticky substance under the overbed table, and the same reddish brown sticky substance was under the edge of the nightstand. During an interview and observation on 11/19/24 at 3:17 p.m., resident #95 said the rooms occasionally get mopped and swept. Resident #95 said the room isn't great but could be worse. An observation was made of heavy black stains on the floor where the flooring meets the cove base. The edges around the door frames had dust, crumbs and debris and was stained dark brown/black in color. (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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NAME OF PROVIDER OR SUPPLIER Village Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2651 South Ave W Missoula, MT 59804	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/20/24 at 11:55 a.m., staff member F said the beds are pulled out and away from the wall and cleaned under every day. Staff member F said room [ROOM NUMBER] had just been completely cleaned. An observation showed room [ROOM NUMBER]-bed 2 was pushed against the wall. There were two tissues, one paper napkin and a loose metal bar which was the same color as the bedframe was laying on the floor disconnected from the bed. Also observed was an accumulation of dirt, dust and hair balls on the floor at the foot of the bed in the corner hear the window. During an interview on 11/20/24 at 3:07 p.m., staff member G said the halls are pretty clean, but the rooms are dirty. Staff member G said the floors in the rooms could be cleaner and the garbage cans need washed. Staff member G said the sweeping and mopping under the beds was a missed opportunity and those areas are dirty, and need cleaned. During an interview on 11/21/24 at 7:55 a.m., staff member S said the facility and the resident rooms are not always clean. Staff member S said the facility has been down a housekeeper and the shifts have not been replaced. Staff member S said the nursing staff try to help, but the facility and the resident rooms are not as clean as they should be. Staff member S said there was a mop available to the nursing staff, but the CNA's (certified nurse assistants) have their own jobs to do as well.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 14005 Based on interview and record review, the facility failed to complete accurate assessments for 1 (#33) of 3 sampled residents who had been involved in two altercations. This deficient practice had the potential to affect resident care and safety as it inaccurately depicted the residents' care needs. Findings include: Review of resident #33's vulnerable resident evaluation dated 9/30/24, showed resident #33 did not have a history of any type of abuse toward others. The evaluation also showed the resident did not have behaviors which make the resident susceptible to abuse by others or behaviors which increase the resident's risk of abuse to others. Review of resident #33's MDS with an ARD of 10/3/24 showed the resident did not have any physical, verbal or other behavior symptoms directed toward others. Review of resident #33's nurse's note dated 10/2/24 showed, .Resident increased his voice .Resident has increasing confusion and increasing upset behaviors . The resident was administered a prn antianxiety medication because of the increasing behavior, agitation and inability of staff to redirect the resident. Review of resident #33's nurse's note, dated 9/28/24, showed resident #33 had anxiety and when presented with reality, his agitation increased, and he began pacing. The behavior was disruptive to other residents who were eating dinner. The resident was medicated due to the behaviors. During an interview on 11/20/24 at 11:00 a.m., staff member E said she had completed the Vulnerable Resident Evaluation on 9/30/24. The evaluation showed the resident did not have a history of abuse toward other or self-abuse. The evaluation was also coded showing resident #33 did not have behaviors which make him susceptible to abuse by others (including other vulnerable residents or adults). Staff member said she was just doing the routine to just get through the evaluation. Staff member E said she should have looked deeper into his behaviors and made sure the evaluation was accurate.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 14005 Based on interview and record review, the facility failed to update resident care plans in a timely manner for 3 (# 1, #16 and #55) of 4 residents sampled for pressure ulcers and failed to revise a resident care plan to show effective behavior interventions following repeated resident to resident altercations for 1 (#33) of 3 residents sampled for behavior. Findings include: 1. Review of resident #1's nurses notes, dated 9/6/24, showed a new wound and the wound care was completed for a stage III pressure ulcer with full-thickness skin loss on the left heel. Review of resident #1's nurses notes written by the certified wound nurse on 9/6/24, showed resident #1 had a left heel wound. The wound nurse applied a dressing which was approved by the medical provider. Review of resident #1's nurses note documented on 9/10/24 showed the wound which was initially assessed as a stage III pressure ulcer was now noted to be a callous. Review of resident #1's care plan showed the care plan was updated on 11/18/24 and the potential for skin alteration changed from a potential to an actual wound. Resident #1's care plan was updated on 11/18/24 to include offloading the heels. 2. A review of resident #16's initial wound care nurses notes dated 10/22/24, showed the resident had a stage III full thickness wound to her right heel. The nurses note showed the physician was contacted to get verification of treatment which was started for resident #16. A review of resident #16's care plan showed no intervention for treatment for resident #16's pressure ulcer on the heel until 11/18/24. Several interventions added on 11/18/24 were to provide a low loss air mattress, off load resident #16's heels and provide Prevalon boots to her bilateral heels. 3. Review of resident #55's skin and wound evaluation dated 10/28/24 showed resident #55 had a new in-house acquired wound described as a pressure ulcer which was staged as a deep tissue injury to her right heel. Review of resident #55's care plan showed the interventions were not updated for the heel wound until 11/18, when an air overlay was placed on the bed, Prevalon boots to be placed as resident will allow. 4. Review of resident #33's nurse's notes dated 8/29/24, showed resident #33 smacked another resident on the left side of his head. Review of resident #33's nurse's noted dated 8/30/24, showed resident #33 was hit twice in the back by another resident. Review of resident #33's care plan showed the care plan had not been updated until 9/10/24. There was no further updates until 10/11/24. The care plan contained the following updates: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 9/10/2024, sitting on the opposite side of the dining room from louder residents, trying to decrease stimuli for him . Suggest he plays piano when he was feeling overwhelmed or wants to express himself through music . - 10/11/2024, Redirection/refocus/diversion/ aromatherapy, and other. 5. During an interview on 11/20/24 at 4:40 p.m., staff member U said the care plans are updated quarterly and annually with MDS assessments. Staff member U said there was a meeting every day and the management gets the updates then. Staff member U said the wound nurse monitors the wounds and the nurse does the care plan updates for wounds. Staff member U said the care plans for other issues are updated by which ever nurse catches the changes.

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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. 14005 Based on interview and record review, the facility failed to limit an as needed anti-anxiety medication order to 14 days or provide a rationale for continued extension of the medication, for 1 (# 33) of 1 sampled resident using an as needed medication. Findings include: A review of resident #33's medication administration record for September 24, showed, Lorazepam Concentrate 2MG/ML, give 0.5ml by mouth every 8 hours as needed for Anxiety for 4 days was ordered on 8/30/24. Lorazepam is the generic name for Ativan, an anti-anxiety medication. The MAR showed the medication had not been given during those 4 days. A review of the September 2024 MAR, showed, on 9/3/24, the medical provider re-ordered the Lorazepam to be continued at 1mg every 6 hours for another 14 days. During those 14 days, the Lorazepam had not been administered. A review of the Advanced Practice Nurse Practitioner note dated 9/6/24 showed she had assessed resident #33. The NP note showed, .9/3-acute visit with Doctor for agitation which had resolved at the time of the visit. As needed Ativan available, none given in the last 14 days. The NP had re-ordered the Ativan on 9/3/24 with no justification or reason indicating the medication should be continued. A review of the September 2024 MAR showed on 9/27/24, the medical provider again re-ordered for the Lorazepam to continue for 6 months. Resident #33 had not received any prn doses of Lorazepam. A review of the September MAR showed the staff began administering the anti-anxiety medication on a prn basis on 9/27/24. A review of resident #33's nurse's notes dated 11/27/24 showed the resident was angry at one staff member. The facility failed to intervene and remove the source of the agitation. An anti-anxiety medication was administered rather than the source of the agitation be addressed and changed. A review of resident #33's physician note dated 11/1/24, showed the physician was aware resident #33 was given Lorazepam 5 times in the last 30 days. The physician did not indicate the reason the medication was administered. The physician did not indicate a rationale or diagnoses why the Lorazepam should be continued. During an interview on 11/19/24, NF1 said he did not sign a consent for the use of the tranquilizer the facility was using to control resident #33. He said he doesn't remember being educated on the risks or benefits of the medication the resident receives. A request was made on 11/19/24 at 2:46 p.m. for documentation showing education and consent for use of Lorazepam for resident #33. No documentation was provided by the end of the survey. A review of a facility policy, Use of Psychotropic Drugs, dated 10/14/24, showed (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- .3. The attending physician will assume leadership in medication management by developing, monitoring and modifying the medication regimen in collaboration with the residents, their families and or representatives, other professionals and the interdisciplinary team. - .4. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed. - . 5. Residents and or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions - . 9. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to extend beyond 14 days, he or she shall document their rationale in the resident's medical record .