STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275044	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Ascension Transitional Care of Cascadia	2475 Winne Ave Helena, MT 59601

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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 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. 32998 Based on interview and record review, it was identified the facility staff were aware of a resident's wound status, and use of a mechanical lift, but failed to develop a care plan problem, goals, or interventions for the prevention of the pressure ulcer to her right heel and back, for 1 (#15); and failed to develop a care plan for pain management for a resident who had pain during wound care, for 1 (#6) out of 5 sampled residents. Findings include: 1. During an interview on 5/20/24 at 8:54 a.m., NF2 stated it appeared like resident #15 was developing more wounds after admission to the facility, and the wounds were not showing improvement. During an interview on 5/20/24 at 9:53 a.m., resident #15 stated she had gotten a skin tear on her back, from the hoyer (mechanical) lift sling, as staff pulled the sling out from under her, rather than use the proper process for removal. The tear was caused by pulling the sling out from under her, rather than rolling her from side to side, to remove the sling. Resident #15 stated the skin tear progressed to a Stage III pressure ulcer. Resident #15 stated she had started going to the wound clinic on 5/15/24. Resident #15 stated staff at the facility was no longer doing her wound care. NF1 was now doing dressing changes per physician orders. Review of resident #15's Braden Scale for Predicting Pressure Sore Risk, dated 3/13/24, showed the resident was at risk for developing pressure ulcers. Review of resident #15's care plan, dated 3/13/24, failed to show problems, goals and interventions for the prevention of pressure ulcers or interventions for the pressure ulcer to her right heel and back. Refer to F686-Treatment Services to Prevent Pressure Ulcers, for more information on resident #15's wounds. 2. During an interview on 5/20/24 at 1:45 p.m., staff member F stated pain medication was to be administered prior to dressing changes, if the resident complained about pain during dressing changes. Review of resident #6's progress notes, dated 3/3/24 through 5/10/24, showed the resident complained of pain to the wound during dressing changes. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #6's MAR, dated 3/1/24 through 5/31/24, showed pain medication was ordered every six hours as needed for pain. The documentation was unclear whether the resident was given pain medication prior to the wound dressing changes. Review of resident #6's care plan, dated 4/29/24, failed to show interventions for pain related to the wound and wound care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 32998 Based on interview and record review, licensed nursing and certified staff failed to follow standards of practice for wound care, for 1 (#6) of 5 sampled residents; Resident #6 developed a pressure ulcer which deteriorated to a Stage IV. It was identified physician orders for treatments were not followed multiple times, over multiple shifts, and on multiple days. Findings include: During an interview on 5/20/24 at 1:30 p.m., staff member D, a certified staff member, stated pressure relieving interventions included turning and repositioning, putting a cushion in their (for a resident with wound) wheel chair, and a different mattress on their bed for pressure relief. Staff member D stated if there was a change in a resident wound appearance, or if there was a new wound, it would be reported to the nurse right away. During an interview on 5/20/24 at 1:40 p.m., staff member E, a certified staff member, stated resident's with wounds were to be turned and repositioned every two hours. Staff member E stated changes in resident's skin would be reported to the nurse right away so it can be assessed. During an interview on 5/20/24 at 1:45 p.m., staff member F, a licensed clinical staff member, stated residents with wounds were to be turned and repositioned every two hours, or as ordered, and to off load pressure areas when in bed, heel protectors were to be worn at all times, and wound assessments completed as ordered. Review of resident #6's admission Skin Inspection and Admission Clinical Evaluation, dated 2/6/24, showed the resident's skin was intact with pink on the pannus and sacrum. Review of resident #6's Progress Note, dated 2/6/24, showed the resident had a Braden score of 12, and she was at high risk for developing pressure ulcers. Review of resident #6's skin/nursing progress notes, dated 2/6/24 through 5/20/24, showed the resident went from intact skin to a Stage IV pressure ulcer by 3/13/24. It was identified, that although staff were able to verbalize beneficial standards of practice for wound prevention, these practices were not followed for #6. Review of resident #6's Wound Care Notes, Nursing Progress Notes, and Wound Clinic Documentation, dated 2/6/24 through 5/17/24, showed there were 17 missed dressings changes, and there were no dressings on the wound when the resident arrived at the wound clinic on 5/3/24 and 5/10/24. Staff failed to follow standards of practice for wound care treatment and prevention, as show by the following: Review of resident #6's physician orders from the wound clinic showed missed dressing changes on the following dates: - 2/16/24 dressing changes were to be done daily. There were six missing days with dressing changes to complete. - 3/1/24 dressing changes were to be done every other day. There was one missed dressing change to complete. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 3/15/24 dressing changes were to be done three times weekly, with the facility doing changes on Mondays and Wednesdays, and the wound clinic doing a dressing change on Fridays. The resident had a wound vac in place. There were four missed dressing changes. - 3/29/24 dressing changes were to be done daily. The wound vac had been discontinued. There were four missed dressing changes. - 4/5/29 dressing changes were to done three times per week. The facility was to do the dressing changes on Mondays and Wednesdays, and the wound clinic was to do the dressing changes on Fridays. There were three missed dressing changes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32998 Based on observation, interview, and record review, the facility failed to ensure 2 (#s 6 and 15) of 4 sampled residents did not develop a new pressure ulcer or have worsening of pressure ulcers. Outcomes included: Resident #6 developed a sacral pressure ulcer in eight days, which worsened to a Stage IV, the pressure ulcer was avoidable, and the resident had pain from the wound. The staff failed to identify, report, and assess the skin as necessary, failed to develop and implement interventions to reduce skin pressure timely, and failed to complete dressing changes as ordered once the wound developed, for #6. For resident #15, the resident developed a Stage III pressure ulcer resulting from a skin tear caused during the provision of care. The facility failed to develop and implement pressure ulcer prevention strategies staff failed to follow physician orders for wound care. Findings include: 1. During an interview on 5/20/24 at 1:30 p.m., staff member D stated pressure relieving interventions included turning and repositioning, placing a cushion in their (resident's) wheelchair, and a the resident having a different mattress. During an interview on 5/20/24 at 1:40 p.m., staff member E stated residents with wounds were to be turned and repositioned every two hours. Staff member E stated changes in a resident's skin would be reported to the nurse right away, so the skin could be assessed. During an interview on 5/20/24 at 1:45 p.m., staff member F stated residents with wounds were to be turned and repositioned every two hours, or as ordered, they were to off load pressure areas (to skin) when the resident was in bed, place heel protectors at all times, and complete wound assessments as ordered. Review of resident #6's admission Skin Inspection and Admission Clinical Evaluation, dated 2/6/24, showed the resident's skin was intact with pink areas on the pannus and sacrum areas. Review of resident #6's Progress note, dated 2/6/24, showed the resident was at high risk for developing pressure ulcers with a score of 12. Review of resident #6's progress notes, dated 2/6/24 to 5/20/24, showed the resident started on admission with intact skin, and then developed a Stage III pressure ulcer. The progress notes showed a progression from a Stage III to a Stage IV from 2/14/24 to 3/13/24. Review of resident #6's Wound Care Notes, Nursing Progress Notes, and Wound Clinic Documentation, dated 2/6/24 through 5/17/24, showed 17 missed dressing changes. The resident went to the wound clinic two times without a dressing on the wound. Review of resident #6's Nursing Progress Notes, for wound care from 2/15/24 to 5/15/24 showed: - 2/6/24 skin intact with pink areas to the pannus and sacrum - 2/13/24 dressing on buttocks intact (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 2/14/24 nursing alerted to worsening wound to left buttock by the CNA and PT. Large open area noted to left buttock approximately 7.0 cm x 5.3 cm. Current wound orders to apply barrier cream to sacrum two times daily. Provider notified. Review of resident #6's physician orders, dated 2/16/24, showed dressings changes were to be done daily. There were six days with missed dressing changes. The dressings were changed on 2/18/24, 2/23/24, 2/26/24, and on 3/1/24 the dressing was changed and the Weekly Pressure Ulcer Report showed it was a Stage III severity. Review of resident #6's physician orders from the wound clinic, dated 3/1/24, showed the resident was to have dressing changes every other day. There was one dressing change missed. The documentation showed: - 3/3/24; Large amount of tan/red odorous drainage noted on old dressing. Resident reported the area was very sore. - 3/5/24 at 4:31 a.m.; There was old dressing saturated with tan and bloody very foul-smelling discharge. Wound bed has clump of tan slough tissue that appears to be loosening off of wound bed. Tolerated dressing change, reported the area is very painful. - 3/5/24 at 5:05 p.m., wound care was provided three times as resident was wet, and dressing was soiled. - 3/7/24 - Pressure injury to buttocks is very painful and increasing in depth. - 3/12/24 through 3/28/24 - A wound vac was in place on the resident's coccyx - 3/15/24 - The resident was to have the wound vac changed three times weekly. There were four missed dressing changes. Review of resident #6's physician orders from the wound clinic showed: - 3/22/24 - Continue the wound vac and keep it set at 125mm/hg pressure and dressing changes were to be done three times weekly. - On 3/29/24 the wound vac was discontinued. - 3/29/24 - The resident was to have daily dressing changes. There were four missed dressing changes. The facility progress notes showed: - 4/1/24 - Wound showed signs of improvement. - 4/8/24 at 4:18 a.m. wound vac in place. At 6:54 a.m. wound vac on hold. - 4/29/24 - Readmission to the facility, as she was transferred to ER after a fall. - 4/29/24 through 5/2/24 dressing changed per orders (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 5/3/24 and 5/10/24 no dressing on wound on arrival to the wound clinic. The resident was yelling out in pain. Review of resident #6's physician orders from the wound clinic, dated 4/5/24, showed dressings were to be done three times weekly with the facility doing dressing changes on Mondays and Wednesdays. There were three missed dressing changes following the receipt of the orders. Review of resident #6's wound care notes showed the following: - 2/14/24 Stage III pressure ulcer measured 7 cm x 5.31 cm. Alerted to change by PT and CNA. Resident reports significant pain. - 2/21/24 Stage III pressure ulcer on sacrococcygeal area. Measured 7.62 cm x 5.86 cm. Dressing changes daily with wound clinic one time per week - 2/29/24 Stage III pressure ulcer, no measurements. Large amount of slough in wound bed made it difficult to assess and measure. - 3/7/24 Stage III. Measured 5.97 cm x 3.94 cm. - 3/13/24 Stage IV. Measured 6.13 cm x 4.36 cm. - 3/20/24 Stage IV. Measured 6.03 cm x 4.89 cm. Wound vac in place. - 3/27/24 Stage IV. Measured 4.84 cm x 3.8 cm. - 4/3/24 Stage IV. Measured 4.66 cm x 3.96 cm. - 4/10/24 Stage IV. Measured 3.69 cm x 2.22 cm. - 4/18/24 Stage IV. Measured 4.17 cm x 3.02 cm. - 4/30/24 Stage IV. Measured 3.1 cm x 2.32 cm. - 5/8/24 Stage IV. Measured 2.56 cm x 1.99 cm. - 5/15/24 Stage IV. Measured 4.37 cm x 1.55 cm. Review of the Wound Clinic documentation showed the following: - 2/16/24 Stage III pressure ulcer of the sacral region. Date acquired 1/24/24. It is unclear when the pressure ulcer developed or what treatment the resident had received thus far. Review of the nursing home H&P did not indicate the resident had a pressure ulcer on admission. The wound measured 6.1 cm x 5 cm x 0.1 cm depth. There was a large amount of serosanguineous drainage noted. The physician noted the wound was a fairly large and devastating pressure injury. I diagnosed at least Stage III. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 2/23/24 Stage III pressure ulcer of sacral region. Patient wound is worse. Concerns of infection are noted. Wound measurements were 5.4 cm x 5 cm x 0.1 cm depth. - 3/1/24 Stage III pressure ulcer on the left gluteus. Wound showed progress. - 3/8/24 Stage III pressure ulcer of sacral region. Pre debridement measurements were 5.2 cm x 4.7 cm x 4 cm depth and post debridement measurements were 4.7 cm x 4.7 cm x 4 cm depth. Post debridement noted as Stage IV. Wound was making progress and had some tunneling. - 3/15/24 Measurements were 5.2 cm x 5 cm x 2.8 cm depth. Stage IV pressure ulcer. Patient continues with some depth and undermining to this wound. The depth has improved; however, it does have some twists and turns in deeper area. Continue with wound vac. - 3/22/24 wound vac in place. Facility nursing removed a white foam from the tunnel area, which was not on the original orders for the wound vac. The white foam was covered with a small piece of black foam which extended onto the right buttock, and the right side now showed breakdown with texture potentially from the wound vac sponge. Facility nursing reported a foul odor when the wound vac sponge was removed. Stage IV pressure ulcer and measured 4.4 cm x 4.3 cm x 2.8 cm depth. There is muscle and fat layer visible with undermining noted. - 3/29/24 Ordered for a break in the wound vac. Wound measured 5 cm x 4.1 cm x 2.8 cm. Stage IV. There was a foul odor following cleansing. Patient's wound has again worsened this week. She has also not yet started her antibiotics. She has a wound vac on which appears to be doing more harm at this point related to malposition of the vac sponge during dressing changes or movement of the sponge after it was placed. She also has a positive wound culture result, not currently on antibiotics, placing her in unnecessary danger by this intervention. Wound cultures had been reviewed by the provider ,and the resident was to be on an antibiotic. - 4/5/24 Stage IV pressure ulcer. Wound measured 3.4 cm x 3.7 cm x 1.1 cm depth. The resident's wound had made good progress. - 4/12/24 Stage IV pressure ulcer. Wound vac discontinued. The wound measures 3.3 cm x 3.7 cm x 0.3 cm depth. There was muscle and fat layer exposed. There was no tunneling or undermining noted. The wound continues to make slow progress. - 5/3/24 Stage IV pressure ulcer. The resident did not have a dressing on her wound when she arrived at the wound clinic. - 5/10/24 Stage IV pressure ulcer. Patient again had NO dressing on wound bed and was yelling out in pain. There was an order to give the resident pain medication 30 minutes prior to her appointment. The wound measured 1.8 cm x 2.2 cm x 0.3 cm. 2. During an interview on 5/20/24 at 8:54 a.m., NF2 stated it seemed like resident #15 was getting more wounds after admission. NF2 stated there was to be an evaluation of size of sling to use, but it had not occurred yet. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/20/24 at 9:53 a.m., resident #15 stated she sustained a skin tear to her left mid back related to the sling from the Hoyer lift. The sling was pulled from under her instead of rolling her side to side. Resident #15 stated after that it was classified as a Stage III pressure ulcer. Resident #15 stated NF1 came to the facility to change her dressings on her back and foot (had wound treatment experience). Resident #15 stated she started going to the wound clinic on 5/15/24, and she started wound care at the Wound Care Clinic the week prior. During an observation on 5/20/24 at 3:17 p.m., NF1 removed the dressing from resident #15's left mid back. The wound was large and covered with eschar with a moderate amount of serosanguineous drainage. During an interview on 5/21/24 at 4:31 p.m., NF1 stated an assessment of the proper sling to use for #15 had not been completed. NF1 stated the facility had used several different slings. During an interview on 5/21/24 at 5:15 p.m., staff members A, B, and C stated resident #15 came into the facility with left lateral foot diabetic ulcer, and multiple areas of scrapes due to falls at home. Staff members A, B, and C stated the resident developed a blister on her right heel on 3/20/24 with a small, opened area at the bottom of the blister. The blister opened up on 4/16/24. Staff members A, B, and C stated the resident's partner began doing dressings on her right foot. Staff members A, B, and C stated the skin tear from the sling happened on 4/30/24, and a foam dressing was applied. On 5/7/24 the skin tear on the left mid back worsened to a Stage III. The provider was notified, and a new order was placed and referral made to the wound clinic as soon as possible. Staff members A, B, and C stated at that point the staff of the facility were doing dressing changes to the resident's back. On 5/15/24, NF1 began doing dressing changes to the resident's wound on her back. Review of resident #15's Braden Scale for Predicting Pressure Sore Risk, dated 3/13/24, showed a score of 15 which showed the resident was at risk for developing pressure ulcers. Review of resident #15's Care Plan, dated 3/13/24, failed to show problems, goals and interventions for prevention of pressure ulcers. The resident had a diabetic ulcer on her left heel, and a pressure ulcer to the right heel and left mid back. Review of resident #15's Foot and Ankle Clinic physician order, dated 5/1/24, showed NF1 was to do all dressing changes to the resident's feet. No staff at the facility were permitted to perform dressing changes. Review of resident #15's Wound Clinic documentation, dated 5/15/24, showed the resident had a Stage III [NAME] ulcer to the left upper back. Review of the orders showed NF1 was to change the dressing on the resident's back. At the time of the appointment at the Wound Clinic, the wound was currently Unstageable/unclassified due to the 67-100% necrotic tissue. There was no tunneling or undermining noted. Post debridement of the wound showed it was classified as a Stage III pressure ulcer, measuring 4.8 cm x 4. 8 cm x 0 depth. The dressing was to be changed three times per week. It was a full thickness and required surgical debridement. The resident refused to be referred to a surgeon. There was one facility assessment, dated 4/30/24, which showed a new blister to #15's lateral left side, related to friction from the Hoyer sling, during transfers. There was a scant amount of drainage present. The wound was cleansed and covered with a 4x4 Opti foam for protection.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32998 Based on interview and record review, the facility failed to ensure 1 (#6) of 3 sampled residents was medicated for pain 30 minutes prior to pressure ulcer dressing changes. Findings include: During an interview on 5/20/24 at 1:30 p.m., staff member D stated complaints of pain were to be reported to the nurse. During an interview on 5/20/24 at 1:40 p.m., staff member E stated if a resident is in pain, the nurse can give them pain medication. During an interview on 5/20/24 at 1:45 p.m., staff member F stated pain medication was to be administered prior to dressing changes if the resident complained about pain during dressing changes. Resident #6 was admitted to the facility on [DATE] and readmitted after surgical repair of a hip fracture related to a fall on 4/29/24. Upon admission, on 2/6/24, the resident had a pink pannus and sacrum, but had no open areas. On 2/13/24 assessment showed the resident's skin worsened, and the provider was notified with orders to apply a dressing and get the resident into the wound clinic as soon as possible. Resident #6's medical record showed the skin concern progressed to a Stage IV. On 5/10/24 the resident's wound was not covered when she went to the wound clinic, and she was yelling out that she had pain. Orders were written for pain medication to be given 30 minutes prior to her appointments with the wound clinic. Review of resident #6's progress notes, dated 3/3/24 through 5/10/24, showed the resident complained of pain to the wound, especially during dressing changes. Review of resident #6's MAR, dated 3/1/24 through 5/31/24, showed pain medication was ordered every six hours as needed for pain. The documentation was unclear whether the resident was given pain medication prior to dressing changes. Review of resident #6's care plan, dated 4/29/24, failed to show interventions for pain related to the wound and wound care.