STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275047	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Health & Rehabilitation Center	510 S 14th St Livingston, MT 59047

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48268 Based on observation, interview, and record review, the facility failed to obtain a medication self-administration physician's order prior to leaving medications at a resident's bedside, for 1 (#4) of 4 residents sampled for medication administration. Findings include: During an observation and interview on 7/2/24 at 7:50 a.m., staff member N left a medicine cup with two Cephalexin 500 mg capsules at resident #4's bedside table for self-administration. In response to whether resident #4 had a current order for self-administration of medications, staff member N stated, Oh, I guess I shouldn't have done that. Staff member N then returned to resident #4's room and observed her taking the medication. Review of resident #4's medical record failed to show a medication self-administration order.

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48268 Based on interview and record review, the facility failed to report a major injury that was not witnessed, and there was not a reliable source for the cause of the injury, to the State Survey Agency, for 1 (#6) of 2 residents sampled for injuries. Findings include: Review of resident #6's medical record showed resident #6 was found on the floor in her room by staff on 5/22/24 at 2:45 a.m., complaining of pain and was transported to the hospital. Resident #6 told the staff she needed to use the bathroom. The medical record did not show when resident #6 was last observed or toileted. Resident #6's most recent MDS assessment,with an ARD of 6/6/24, showed resident #6 had a BIMS (Brief Interview for Mental Status) score of two, showing low level cognitive function and recall, and the resident was not a reliable reporter. Review of the physician hospital discharge summary note, dated 5/31/24, showed resident #6 was diagnosed with a pelvic fracture, and experienced significant blood loss, requiring intravenous fluids, three blood transfusions, and evacuation of a large hematoma from the pelvis. Resident #6 was hospitalized for nine days after the fall on 5/22/24. Review of Facility Reported Incidents showed the incident which caused the major injury was never reported to the State Survey Agency as an unknown injury. During an interview on 7/3/24 at 9:32 a.m., staff member A stated resident #6's unwitnessed injury should have been reported. Staff member A stated she thought it had been submitted through the reporting portal already, but it had not been.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 48268 Based on interview and record review, the facility failed to provide evidence for the reporting, investigation, and follow up actions taken to protect residents, for an allegation of a resident-to-resident verbal abuse to the State Survey Agency for 4 (#s 6, 11, 20 and 32) of 25 sampled residents. Findings include: 1. Review of a Facility-Reported Incident, dated 12/4/23 and submitted to the State Survey Agency reporting system on 12/4/23, showed there was a verbal assault between resident #20 and his roommate, resident #32. The report showed resident #20 verbally threatened to kill resident #32, causing resident #32 to be fearful of staying in their shared room. The report showed resident #32 was removed from the room for safety. The facility investigation documentation was requested on 7/1/24 related to the 12/4/23 resident-to-resident verbal altercation, and no documentation or report of findings was received by the end of the survey period on 7/3/24. 2. Review of a Facility-Reported Incident, dated 1/16/24 and submitted to the State Survey Agency reporting system on 1/16/24, showed there was a verbal assault between resident #6 and resident #11. The report showed both residents were cognitively impaired, and both residents were separated for safety. The complete facility investigation documentation was requested on 7/1/24 related to the 1/16/24 resident-to-resident verbal altercation, and no report of findings for the investigation was received by the end of the survey period on 7/3/24. During an interview on 7/3/24 at 9:32 a.m., staff member A stated after investigating the reportable incidents at the surveyor's request, the facility did not submit a report of findings for the 12/4/23 or 1/16/24 resident-to-resident incidents.

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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 49554 Based on interviews and record reviews, the facility failed to provide residents or their representatives with a summary of their baseline care plan for 3 (#'s 14, 144, and 145) of 6 residents sampled for baseline care planning. Findings include: During an interview on 7/1/24 at 2:33 p.m., NF2 stated, (Resident #145) hasn't been in this facility that long, and I'm not sure what his plan of care is. During an interview on 7/1/24 at 2:41 p.m., resident #144 stated, I haven't participated in a care plan. I would like more therapy to gain strength to go home. No one has talked to me about discharge; I don't know what the plan is. During an interview on 7/1/24 at 3:27 p.m., resident #14 stated, The facility hasn't talked to me about my plan of care. I do know that therapy is helping; I'm seeing progress in my legs. During an interview on 7/3/24 at 7:59 a.m., staff member G stated, Social services usually invites the resident and representatives to the care plan meetings and obtains the signatures on the baseline care plan. Staff member G stated they are trying to get electronic signatures up and going for the care plans, but the baseline care plan should be signed and scanned into the residents EHR under documents. During an interview on 7/3/24 at 8:44 a.m., staff member G stated, There were no signatures in their charts, and I couldn't find anything for the baseline care plan signatures scanned into their EHR either. Review of resident #14, 144, and 145's EHR showed there was no evidence the resident or resident representative was provided a summary of the baseline care plan or was notified of the plan of care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50245 Based on observation, interview and record review, the facility failed to identify if a wound was unavoidable or not, and the facility failed to ensure proper wound care treatments were performed for 1 (#8) of 1 sampled resident for wound care. Findings include: During an interview and observation on 7/3/24 at 12:22 p.m., resident #8 had a dressing to her right lower shin that showed a date of 6/30/24 at a time of 2030 (8:30 p.m.). The physician's order showed to change the dressing every other day. Staff member H removed the old dressing to the right lower shin wound which showed no calcium or silver alginate on the dressing. Staff member H stated she did not think she saw calcium or silver alginate in the dressing she was removed. The wound characteristics upon observation were: a shallow open wound about the size of a dime; the wound bed was red in color; the surrounding tissue was pink and moist with loose intact skin on the superficial surface; no observation of fascia, muscle, bone, or slough. Review of resident #8's physician order showed, Wound care to Right Shin: Cleanse wound and apply alginate with silver or calcium alginate Ag and foam dressing change every other day. [sic] Review of resident #8's EHR showed the wound care was missed five times in the eight opportunities in May 2024. Review of resident #8's EHR showed thirteen wound care treatments were missed out of the fifteen opportunities in June 2024. Review of a facility provided document titled, Resident Matrix, dated 7/1/24, showed resident #8's wound was a Stage 2 pressure injury. Review of resident #8's Weekly Skin Evaluations showed measurements, characteristics, and improvements or a decline in status, but failed to show documentation of the stage (description/severity) of the pressure injury. Review of resident #8's Care Plan, initiated 6/13/23, showed, Monitor/document/report PRN any changes in . wound size (length X width X depth), stage. During an interview on 7/3/24 at 2:30 p.m., staff member A stated the facility did not have the Nutrition Hydration Skin Committee Meeting minutes or the comprehensive review of resident #8's medical record to evaluate if the pressure ulcer was avoidable or unavoidable per the facility Skin Integrity policy. During an interview on 7/3/24 at 2:33 p.m., staff member C stated she did not do audits or education at this time to ensure the staff was performing wound care treatments properly and per the physician orders. Staff member C later stated, That would be a good idea. Review of the facility provided document, dated October 2022, titled Skin Integrity, showed: . 7. If skin impairment is noted after admission . the LN: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. The DNS and/or designee complete a comprehensive review of the resident's medical record to evaluate if the Pressure Ulcer was avoidable or unavoidable. This evaluation is documented in the Nurse's Notes. 8. Non-Healing Wounds/Pressure Ulcers/Burns are reviewed at the Nutrition Hydration Skin Committee Meeting.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48268 Based on observation, interview, and record review, the facility failed to ensure medication error rates were under 5%, which affected 2 (#s 1 and 8) of 4 residents sampled for medication administration. The calculated medication error rate was 15%. Findings include: 1. During an observation on 7/2/24 at 7:43 a.m., staff member N administered the following medication to resident #1: - Staff member N dispensed a one gram tablet of Sodium Chloride. The physician's order was for a two gram total dose. The surveyor questioned staff member N on the amount of Sodium Chloride dispensed, and staff member N pulled an additional one gram tablet of Sodium Chloride from the bottle, for administration to resident #1. 2. During an observation on 7/3/24 at 8:26 a.m., staff member H administered the following medication to resident #8: - Insulin Glargine injection, 100 units/milliliter, 38 units subcutaneously - Insulin Aspart injection,100 units/milliliter, three units subcutaneously Staff member H did not prime the Aspart or Glargine insulin pens prior to administration. A review of the facility's policy titled, Medication Administration General Guidelines, dated 1/23, and updated 1/24, showed: - . 9. Verify medication is correct three (3) times before administering the medication . a. When pulling the medication package from the med cart . b. When dose is prepared . c. Before dose is administered. A review of the facility's policy, Medication Administration Subcutaneous Insulin, dated 1/23, showed: . Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: - ensuring that pen and needle work properly . - removing air bubbles . D. Hold the pen with the needle pointing upwards. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. E. Tap the insulin reservoir so that any air bubbles rise up towards the needle. . F. Press the injection button all the way in. Check if insulin comes out of the needle tip. [sic] A review of manufacturer instructions for the use of both Glargine and Aspart insulin pens included industry standard instructions for priming an insulin pen prior to each use, using a two-unit setting, holding the pen upright, releasing the pen trigger, followed by ensuring that a drop of insulin is visible on the tip of the needle before administering the required dose.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49554 Based on observation, interview, and record review, the facility failed to sufficiently staff the dietary department with the necessary staff to carry out the normal functions of the department. This deficient practice had the potential to affect all residents served meals by the dietary department, by causing meals to be served late, and not meeting resident preferences. Findings include: During an interview on 7/1/24 at 11:10 a.m., NF3 stated there were some identified concerns with staffing and food; mostly dietary staffing and late mealtimes. During an observation on 7/1/24 at 12:35 p.m., the noon meal was supposed to be served at 12:00 p.m. and had not been served to the residents. There were residents in the dining room waiting for the meal to be served. During an observation on 7/1/24 at 12:53 p.m., the staff announced over the intercom that lunch was ready and being served. Staff started serving the residents in the dining room at this time. During an interview on 7/1/24 at 2:33 p.m., NF2 stated she had noticed the meals were being served late. During an interview on 7/1/24 at 2:45 p.m., resident #23 stated, The kitchen is short-staffed, but they are doing the best they can with what they have. During an interview on 7/1/24 at 3:30 p.m., resident #5 stated, I don't think the staff have spoken to residents about their food preferences. The meals are often served late, and I can see how much is being wasted just by sitting in the dining room and watching others eat. During an observation on 7/2/24 at 12:01 p.m., residents were in the dining room waiting for lunch, and meal service had not started yet. During an observation on 7/2/24 at 12:13 p.m., staff were starting to serve the dining room residents their 12:00 p.m. meal. There were more staff serving meals than the previous day. During an observation on 7/2/24 at 12:32 p.m., residents in their rooms had not been served lunch. During an interview on 7/3/24 at 9:22 a.m., staff member M stated, We only have five staff members in the dietary department, and that includes the manager. We need more staff, and I know the facility is looking for more staff. I know on Monday lunch was served around 1:20 p.m. During an interview on 7/3/24 at 9:33 a.m., staff member L stated, Meals are sometimes served late. We help the kitchen as much as we can since they don't have that many staff. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/3/24 at 9:42 a.m., staff member E stated, We have five staff members that work in the dietary department. We are supposed to get the residents meal preferences on admission, but I haven't had a chance to stay on top of that since I am working in the kitchen so much. I have been trying to address preferences along with serving times being so late. Review of a facility document titled Mealtimes showed meals are to be served at 8:00 a.m., 12:00 p.m., and 6:00 p.m. Review of the facility assessment with a completed date of 5/20/24 showed, Census, Capacity, and Staffing Quarter 2: Total number Warranted for Basic Staffing Needs Food and Nutrition Services Manager: 1 Food and Nutrition Services: 8

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 50245 Based on observation, interview and record review, the facility failed to ensure proper management of the communal resident personal food refrigerator and freezer. Findings include: During an interview and observation on 7/1/24 at 11:24 a.m., staff member E stated her department was not responsible for monitoring the resident personal food refrigerator. Staff member E was unsure who cleaned or who monitored the temperatures to ensure the food was stored safely in the communal resident personal refrigerator and freezer. Staff member E stated she assumed nursing staff or maintenance staff were responsible for these duties. The resident personal food refrigerator and freezer did not have temperature logs located on the outside of the doors. The other freezers and refrigerators in this room that were used by kitchen staff had temperature logs showing daily temperatures were completed. In the resident personal food refrigerator, half of a piece of fruit was wrapped in a paper towel. This item was not in a closed container and was not dated. The fruit was located in a plastic bag with a resident's name that was difficult to read written in Sharpie. During an interview on 7/1/24 at 3:11 p.m., resident #8 stated, Supposedly no one is in charge of it (the resident personal refrigerator). Resident #8 stated $50 worth of her groceries were thrown away because staff was unsure how old her food was. Resident #8 stated she buys groceries specific to the vitamins and minerals that she is lacking (calcium, vitamin E, iron, and protein) and she was frustrated that staff members were throwing these foods away that she specifically bought for her conditions. Resident #8 stated she had tried to speak with multiple staff about the food being thrown away, but there was never any resolution. During an interview on 7/2/24 at 12:46 p.m., staff member I stated the responsibility should be the kitchen staff. Staff member I stated, kitchen staff monitor temperatures for the other refrigerators and freezers in that room. During an interview on 7/2/24 at 6:54 p.m., staff member J stated, I'd assume the kitchen (staff) manages the resident personal fridge. Staff member J stated she always assumed kitchen staff or management cleaned and monitored the refrigerator temperature, but she was unsure who was assigned to this duty. Review of a facility provided document, titled: Foods Brought Into Center by Family/Visitors and Resident Personal Refrigerators, dated August 2020, showed: . 6. Refrigerators containing resident food have thermometers and daily temperature logs with temperatures documented. Temperature standards: refrigerator 35-40 degrees Fahrenheit, freezer < or equal to 0 degrees Fahrenheit. Temperatures outside of these standards are reported to the Dietary Manager or Person in Charge. It is suggested that the Food Labeling Reference Guide be posted nearby as a reference . . 7. Perishable foods are covered, labeled, dated, and discarded following use by date guidelines on the Food Labeling Reference Guide. Center staff is responsible for providing education to resident and family on food/fluid labeling and dating . [sic]