STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275061	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan Health Care Center - Shelby	630 Park Drive Shelby, MT 59474

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 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** 46400 Based on interviews and record reviews, the facility failed to prevent, assess, and document the progression of a Stage 4 pressure ulcer for 1 (#7) of 2 residents sampled for pressure ulcers. This deficient practice was corrected in December of 2023. Findings include: Review of resident #7's Re-entry MDS, dated [DATE], showed the resident was readmitted to the facility where she has resided since 2018. On this readmission she did not have a sacral pressure ulcer. Review of resident #7's EMR diagnosis, dated 9/4/23, showed, Pressure ulcer of sacral region. Review of resident #7's [Clinic Name] wound care progress note, dated 11/6/23, showed, The pressure ulcer on the sacrum has been present for 9 weeks [August/September 2023] . According to the NPIAP staging system, the pressure ulcer is classified as Stage IV . Review of resident #7's skin and wound assessments, dated 2023 - current: - There was no weekly skin or wound assessment until 9/25/23. - There were no weekly skin assessments for the months of October 2023 or November 2023. - Weekly skin assessments occurred consistently after the initiation of the facility Wound Care PIP in December 2023. During an interview on 5/7/24 at 10:47 a.m., staff member C stated new management had started at the facility and immediately identified wound care as a concern. The QAPI team initiated a PIP in December of 2023. Staff member C stated they had identified a lack of pressure reducing mattresses and pads, as well as poor layering of linen and plastic pads under residents, as contributing factors to skin concerns. They had also identified a lack of wound documentation. Staff member C stated there had been major improvements in skin and wound care since the initiation of the PIP. Staff member C stated the residents in the facility with wounds had decreased and was currently at two residents with chronic wounds, which were also improving. There were no new resident wounds. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/8/24 at 11:10 a.m., staff member C stated resident #7 was up in her chair early for lunch and an observation of the wound would not be possible prior to the survey exit. Staff member C stated she did the wound measurements and communication with the facility's new medical director weekly. The pressure wound to resident #7's coccyx had shown a decrease in the measurements since December 2023 and had new skin growth around the edges. Review of a facility QAPI performance improvement plan, dated 12/26/23, showed the new management at the facility initiated a performance improvement plan on wound care processes. A root cause analysis was done. Immediate interventions included: - Pressure reduction mattresses and pads, - Change from plastic to cloth bedding protectors for better air flow to skin, - Weekly graphing of wounds, and - Wound care protocol for consistency of wound care/nutritional interventions. Review of the Wound Care Process Meeting Minutes, dated 1/26/24, showed after implementing the identified interventions one month into the plan the facility had four resident skin issues which had healed. There were no new residents with skin issues. The bath aide reported skin redness and irritation was decreased across the high risk population. Meeting frequency was shown to continue weekly with summaries on the noted changes. The target date listed was 6/23/24 and the plan status showed ongoing. Review of the new facility policy, Wound Management, dated 2/2024, showed criteria for wound assessments, progress notes, interventions, and notifications. IDT to include dietary, wound care, and physician involvement.

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F 0727 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on interview and record reviews, the facility failed to ensure a registered nurse was on staff at least eight consecutive hours a day, seven days a week. This practice had the potential to affect any resident needing RN services when one was not available. Findings include: Review of the CMS [NAME] Payroll-based Journal for the facility, with a run date of 4/30/24, showed the facility triggered for not having RN coverage for eight consecutive hours each day on 91 days between the dates of 10/1/23 and 12/31/23. Review of the facility's nursing schedules, dated 10/1/23 - 12/31/23, reflected the facility did not have RN coverage for eight consecutive hours on 12/9/23 and 12/10/23. All other dates did include registered nurse coverage for eight or more hours. During an interview on 5/8/24 at 8:05 a.m., staff member B stated she did not see a RN on the schedule on [DATE] and 10, 2023. Staff member B stated she covered shifts if there was a call off on a weekend and was the RN coverage for weekdays, when necessary, but could not explain the weekend of December 9-10, 2023. Staff member B stated if she had covered the shifts she would be listed on the schedule. Review of the facility's policy, Staffing, Sufficient and Competent Nursing, with a revision date of August 2022, reflected: - .3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven days a week.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48261 Based on observations, interviews, and record review, the facility failed to post the nurse staffing information on a daily basis, at the beginning of each shift. This practice had the potential to affect anyone who wanted to review the nurse staffing levels in the facility. Findings include: During an observation on 5/6/24 at 11:30 a.m., the facility nurse posting was not found on any wall or public area on the unit. During an observation on 5/7/24 at 8:40 a.m., the facility nurse posting was not found on any wall or public area on the unit. During an interview on 5/8/24 at 8:55 a.m., staff member B stated she was not aware of the requirement for a nurse staff posting. Staff member B stated she asked her predecessor who also stated she was not aware of the required posting. Review of the facility's policy, Nurse Staffing Posting Information, with a revision date of February 2023, reflected: - .2. The facility will post the Nurse Staffing Sheet at the beginning of each shift. - .3. The information posted will be: - .b. In a prominent place readily accessible to residents and visitors.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48261 Based on interview and record review, the facility failed to electronically submit accurate and complete direct care staffing information to CMS. This practice had the potential to affect all residents. Findings include: Review of the CMS [NAME] Payroll-based Journal for the facility found the facility triggered concerns for licensed nurse staff on 91 days, between 10/1/23 and 12/31/23. The facility also triggered for not having RN coverage for eight consecutive hours each day on 92 days between 10/1/23 and 12/31/23. Refer to F727 for the RN staffing. Review of the facility's nursing schedules, dated 10/1/23 - 12/31/23, reflected the facility did have licensed staff 24 hours a day on the dates in question, and did have RN coverage for eight consecutive hours each day except on 12/9/23 and 12/10/23. The findings were inconsistent with the PBJ submittals. During an interview on 5/6/24 at 3:15 p.m., staff member A stated she was aware of an issue with the PBJ. She stated she had the PBJ report and completed the PBJ but it was past the deadline and wouldn't accept it. Staff member A stated she thought she had another day to post the report but realized the next morning that she had past the deadline.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48261 Based on observation, interview, and record review, the facility failed to ensure proper hand hygiene was used during wound care for 1 (#5) of 3 sampled residents with wounds, and failed to provide wheelchairs in good repair, including cleanable surfaces, for 5 (#s 13, 14, 15, 18, and 20) of 17 sampled residents. Findings include: 1. During an observation on 5/7/24 at 11:02 a.m., staff members C and F entered the room of resident #5 to provide wound care. Resident #5 was on enhanced barrier precautions for Multidrug-resistant organisms. Both staff members C and F washed their hands and donned gloves upon entering the room. Staff member C began to prep the wound care supplies while staff member F moved the bed, and uncovered resident #5. Staff members C and F each assisted in removing the soiled brief and rolled resident #5 onto her right side. Staff member C removed the wound dressing. Staff members C and F both assisted in cleaning resident #5's buttocks. Staff member C cleaned the wound with wound wash and changed her gloves without hand hygiene between old gloves and new gloves. Staff member C measured the wound, placed a new bandage with antiseptic gel, and placed a 4x4 pad on the wound. Staff members C and F both assisted with placing a new brief and bed pad, rolling resident #5 to each side while putting on the brief and placing the bed pad. Staff member C removed her gloves and washed her hands. Staff member F continued to assist resident #5 to get dressed and place bedding. Staff member F failed to change gloves or complete hand hygiene between clean and dirty tasks from the time cares began until leaving the room. During an interview on 5/7/24 at 11:30 a.m., staff member C stated she should have completed hand hygiene between glove changes. Staff member C also stated staff member F should have completed glove changes and hand hygiene between clean and dirty tasks. Staff member C stated, We know we should, just got nervous, I guess. We usually do wash between gloves. During an interview on 5/8/24 at 9:16 a.m., staff member G stated she completes environmental care audits throughout the building but had not watched wound care hand hygiene. Staff member G stated this was an area she would need to consider adding to her list. Staff member G stated all staff should complete hand hygiene when completing tasks between dirty and clean tasks and between glove changes. Review of the facility's policy, Hand Hygiene, IPC104, last revised 5/2022, reflected: - 1.Perform hand hygiene: - . E. Immediately after the removal of gloves, including between the exchange of dirty to clean gloves. 2. During an observation and interview on 5/6/24 at 2:41 p.m., resident #15 was sitting in his wheelchair, in his room, picking at the padding that was protruding from holes in his wheelchair arm rests. Both arm rest pads were damaged with tears, and the white padding was exposed. Resident #15 was unable to speak about his wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation and interview on 5/7/24 at 12:10 p.m., resident #20 was eating lunch in the dining room. Resident #20's right armrest was covered with a foam pool noodle and taped in place with plastic medical tape. The tape was dirty and discolored. Resident #20 stated the staff had placed the pool noodle on the armrest to help keep her from developing a skin tear. Resident #20 stated the pool noodle and tape had not been changed or cleaned, as far as she knew. During an interview on 5/7/24 at 1:50 p.m., staff member D stated, We don't do that (clean chair), we just do work orders when they come in, when asked if he had a regular maintenance schedule for wheelchairs and equipment. Staff member D stated he did not keep a record or documentation of work orders. 4. During an observation and interview on 5/7/24 at 2:51 p.m., resident #18's wheelchair arm rests were damaged with tears, and the white padding was exposed. Resident #18 stated his chair had been torn as long as he had been using the wheelchair. He could not recall a specific timeline when he received the wheelchair. 5. During an observation on 5/7/24 at 3:01 p.m., resident #14 was sitting in the common area. Resident #14's left wheelchair arm rest had a hole at the end, and the white filling was exposed. Resident #14 was unable to answer questions related to his wheelchair repairs. 6. During an observation on 5/7/24 at 3:03 p.m., resident #13 was sitting in his wheelchair, in the common area. Resident #13's right wheelchair arm rest had a hole, and the padding was exposed. Resident #13 was not able to respond to questions regarding his wheelchair. Review of a facility policy, Preventive Maintenance for Wheelchairs, dated 1/2023, reflected: - . 2. All staff have a responsibility to ensure that wheelchairs in need of repairs are not used and are reported for repairs. - . 4. Preventive Maintenance should be performed weekly or as indicated: - . e. Check seats, backs, arm rests and cushions for tears, cracks or missing screws-replace or repair if present. - . 5. If the wheelchair fails any element of the preventive maintenance check, the wheelchair should be identified for repair and taken out of service until the repair is completed. During an interview on 5/7/24 at 3:50 p.m., staff member D stated, I've never seen that policy (Preventive Maintenance for Wheelchairs) before and know nothing about it, when asked about the preventative maintenance program referenced in the facility provided policy. During an interview on 5/8/24 at 8:10 a.m., staff member B stated staff member D should be aware of the prevention program, and she did not know why he was not actively assessing the wheelchairs. Staff member B stated the night shift staff on the unit cleaned the wheelchairs. Staff member B stated there was no formal record of work orders, and most of the time she would text or call staff member D, if something was needed.