STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275067	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendive Medical Center N H	202 Prospect Dr Glendive, MT 59330

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652 Based on observation, interview, and record review, the facility failed to implement a comprehensive, resident-centered care plan which identified the resident's history of recurrent urinary tract infections and the interventions related to prevention of urinary tract infections for 1 (#9) of 19 sampled residents. Findings include: During an interview on 7/29/24 at 1:40 p.m., resident #9 was sitting up in her recliner. Resident #9 stated she has a history of urinary tract infections and has been on antibiotics for them. Resident #9 stated she experienced frequency in the past when she was diagnosed with a urinary tract infection. During an interview on 7/31/24 at 8:54 a.m., staff member N stated resident #9 needed assistance with toileting and appropriate perineal care after urinating and was encouraged to increase fluid intake. During an interview on 7/31/24 at 9:20 a.m., staff member F stated resident #9 had received antibiotics for treatment of urinary tract infections. The resident was also started on probiotics and cranberry pills in May of 2024 for prevention of urinary tract infections. Review of resident #9's MAR, dated May of 2024, showed the resident received Cipro 500 mg twice daily from 5/7/24 to 5/14/24 for the treatment of a urinary tract infection. Review of resident #9's EHR, accessed on 7/31/24, showed the following nursing progress notes: - 5/3/24, resident complained of slimy urine, increased fluid intake, - 5/7/24, resident complained of urinary frequency and foul-smelling urine, urinalysis collected and sent to the lab, started on Cipro, - 6/21/24, resident complained of urinary frequency, - 6/23/24, resident complained of suprapubic discomfort and was started on Keflex, and - 6/26/24, urine culture results received, antibiotic changed to Bactrim DS until 7/3/24. (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #9's MAR, dated June of 2024, showed the resident received Keflex 500 mg four times a day from 6/23/24 to 6/26/24 and Bactrim DS twice daily from 6/27/24 to 7/3/24. Both the Keflex and Bactrim DS were administered for a urinary tract infection. Review of resident #9's care plan, dated 7/25/24, failed to show a focus area related to recurrent urinary tract infections or goals and interventions for the prevention of urinary tract infections. During an interview on 8/1/24 at 11:20 a.m., staff members B and E stated care plans were updated on a quarterly basis, but they were working on a process for more real time updating of care plans. Staff member B stated resident #9 was admitted on [DATE] and was due (in late July of 2024) for her first quarterly care conference.

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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. 41652 Based on observation, interview, and record review, the facility failed to update resident care plans when changes to the resident's care occurred for 4 (#s 13, 14, 24, and 137) of 19 sampled residents. Findings include: 1. During an observation and interview on 7/31/24 at 8:36 a.m., resident #137 was seen with an ostomy appliance on his stomach, and a white adhesive bandage located just below the resident's ostomy. Resident #137 also had a urinary drainage bag hanging from the bed frame. Resident #137 stated he had a small wound below his ostomy which was covered with a dressing because it drained on occasion. Staff member P pointed out the ladybug sticker on the resident's name plate which indicated the resident was on enhanced barrier precautions because of his ostomy, urinary catheter, and abdominal wound dressing. Staff member P stated she had to wear a gown if she changed the resident's wound dressing. Review of resident #137's care plan, dated 7/16/24, showed the resident had rectal cancer resulting in the placement of a colostomy and urinary retention necessitating a urinary catheter. The care plan failed to show the need for enhanced barrier precautions and what interventions were in place because of the resident's diagnoses. 2. During an observation on 7/31/24 at 8:04 a.m., resident #24 was dressed in street clothes and sitting in a chair near the nurse's station. Resident #24 had a urinary drainage (leg bag) protruding below the hem of her left pant leg. Review of resident #24's care plan, initiated on 7/5/23 and last revised on 6/25/24, showed the resident had a urinary catheter in place because of urinary retention. The care plan failed to show the resident was on enhanced barrier precautions because of the catheter. 3. During an observation on 7/29/24 at 2:37 p.m., resident #14 was lying in bed with her eyes closed. The resident's tube feeding was infusing at 65 ml/hr on a feeding tube pump. There was a ladybug sticker on the resident's name plate, indicating the use of enhanced barrier precautions. Review of resident #14's care plan, initiated on 7/21/23 and revised on 7/9/24, showed the resident had a feeding tube for nutritional support. The care plan failed to show staff were to use enhanced barrier precautions when working with the resident's feeding tube. During an interview on 8/1/24 at 8:30 a.m., staff member C stated enhanced barrier precautions were implemented when residents had tubes, drains, and wounds. Staff member C stated a ladybug sticker was placed on the resident's name plate which meant the resident had drains or tubes which necessitated additional infection prevention strategies. Staff member C stated she maintained a list of residents who were to have enhanced barrier precautions. Staff member C could not explain why the enhanced barrier precautions were not identified on resident #s 14, 24, and 137's care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), dated 4/5/24, showed, 1. Enhanced Barrier Precautions (EBP) are indicated for residents with any of the following: . b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. The policy also showed, EBP is employed when performing the following high-contact resident care activities: . g. Device care or use: central line, urinary catheter, feeding tube . 4. During an observation on 7/30/24 at 8:50 a.m., resident #13 was seated in a recliner near the nurse's station. Resident #13's bed was made and a foot cradle was present. Resident#13 did not interact with staff and sat in the chair with her eyes closed. During an interview on 7/31/24 at 9:04 a.m., staff member O stated resident #13 was assisted by one staff member for dressing and personal cares. Staff member O stated the resident had a foot cradle on her bed, so her blankets did not put excess pressure on the tops of her toes. Staff member O stated the staff also used lotion on the resident's skin to prevent excessive dryness. Review of resident #13's physician orders, dated 3/1/24, showed the addition of a foot cradle for the prevention of breakdown on the tops of the resident's toes. Review of resident #13's care plan, initiated on 7/7/23 and revised on 3/26/24, showed the resident was at risk for impaired skin integrity with the goal of intact skin. The interventions on the care plan failed to show the use of a foot cradle. During an interview on 8/1/24 at 11:20 a.m., staff members B and E stated currently care plans were only updated quarterly at the time of each resident's MDS completion and quarterly care conference. Staff member E stated she was working on a process which would allow for more real-time revisions to the resident care plans.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41652 Based on interview and record review, the facility failed to ensure a registered pharmacist performed medication regimen reviews at least monthly for 1 (#33); and failed to ensure the physician addressed the pharmacy recommendations and irregularities timely for 2 (#s 4 and 24) of 19 sampled residents. The facility also failed to maintain a policy and procedure for monthly medication regimen reviews which identified documentation required and the time frames for the steps taken by the pharmacist when an irregularity was identified. The deficient practice had the potential to affect all residents receiving medication at the facility. Findings include: 1. Review of resident #4's MRR, dated 4/18/24, showed staff member Q recommended a GDR for mirtazapine, paroxetine, and risperidone. The physician did not address the recommendation until 5/31/24, resulting in a six week delay (4/18/24 to 5/31/24). Review of resident #4's mood and behavior team note, dated 6/19/24, failed to show documentation a physician or pharmacist was present for the GDR discussion. Review of resident #4's MRR, dated 7/4/24, showed staff member Q requested a GDR review. There was a handwritten note (not dated or signed) which showed, GDR discussed 6/19/24. The provider did not address the recommendation until 7/30/24, resulting in a six week delay (6/19/24 to 7/30/24). During an interview on 7/31/24 at 2:15 p.m., staff member Q stated he was new to the MRR process and was responsible for MRRs starting in April of 2024. Staff member Q stated he requested the mood and behavior team discuss the GDRs for resident #4 during the April (2024) meeting. Staff member Q stated he was not sure what documentation was required for the MRRs and GDRs which were requested. There was no documentation of recommendations or irregularities identified by staff member Q and addressed by the attending provider which showed the medication name and dose for the recommended GDRs. The mood and behavior team note for 6/19/24 did not contain documentation a physician or pharmacist was present. 2. Review of resident #24's MRR, dated 3/18/24, showed staff member Q recommended continuing Protonix at the same dose due to the resident's high risk of gastrointestinal bleeding, recommended Duonebs and Tessalon Perls be discontinued due to non-use, and recommended changing from risperidone to Seroquel due to the increased risk of EPS associated with risperidone use. The recommendations were not addressed until 5/31/24, resulting in a 10 week delay (3/18/24 to 5/31/24). Review of resident #24's MRR, dated 4/19/24, showed two medication orders did not have a corresponding diagnosis in the resident's EHR. The recommendations were not addressed until 5/31/24, resulting in a six week delay (4/19/24 to 5/31/24). Review of resident #24's mood and behavior note, dated 6/5/24, failed to show the pharmacist or the attending provider were present for the GDR discussion. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #24's MRR, dated 7/4/24, showed a request for a GDR review. There was a handwritten note (not dated or signed) which showed, Done - GDR discussed 6/5/24. The attending provider addressed the recommendation on 7/30/24, resulting in an eight week delay (6/5/24 to 7/30/24). During an interview on 7/31/24 at 2:15 p.m., staff member Q stated he was new to the MRR process. Staff member Q stated he was familiar with the regulations associated with nursing home residents but was unsure what the process was supposed to look like. Staff member Q was not aware the pharmacist was responsible for the identification of irregularities in the resident's medication regimen. There was no documentation by the pharmacist and addressed by the attending provider which identified the medication name and dose for the medications recommended to have a GDR. The mood and behavior team note for 6/5/24 included the necessary medication information but did not contain documentation of the presence of the pharmacist or the provider. 3. Review of resident #33's MRR, dated 7/30/24, showed, ADDENDUM TO JUNE 2024 REPORTS: No concerns or recommendations at this time. The form was signed by the attending provider on 7/30/24. Review of resident #33's EHR, accessed on 7/31/24, failed to show an MRR was completed within 30 days of the resident's admission on 6/4/24. During an interview on 7/31/24 at 2:15 p.m., staff member Q stated he was not sure if an MRR was done for resident #33 during the first 30 days after the resident was admitted to the facility (6/4/24). Staff member Q stated he was not able to find documentation of an MRR done after the resident's admission on 6/4/24. Review of the facility policy titled, Drug Regimen Review, not dated, failed to show the steps to be taken by the pharmacist during the medication review and the time frames associated with each of the steps. The policy failed to show the process for resolving situations involving a disagreement between the pharmacist's recommendation and the attending provider's orders for resident care. The policy also failed to identify what should be done if the anticipated length of stay was less than 30 days.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652 Based on observation, interview, and record review, the facility failed to ensure orders for as needed psychotropic medications did not exceed 14 days unless the rationale was documented by the provider for 1 (#33) of 19 sampled residents. Findings include: During an observation and interview on 7/29/24 at 1:56 p.m., resident #33 was walking in the hallway using a front-wheeled walker. When asked what brought her to the facility, resident #33 stated her memory was not very good and she was not sure. No pacing or exit-seeking behavior was seen. Review of resident #33's medication orders, dated 7/7/24, showed an order for lorazepam 0.5 mg every four hours as needed for anxiety. The order was still in place and active as of 7/30/24. During an interview on 7/31/24 at 8:28 a.m., staff member F stated resident #33 became restless, began pacing or looking for her purse when she was anxious. Staff member F stated the resident responded well to redirection and distraction techniques. During an interview on 7/31/24 at 2:15 p.m., staff member Q stated he became responsible for medication regimen reviews some time in April of 2024. Staff member Q stated he got some training from the previous consultant pharmacist, but was new to the nursing home regulations. Staff member Q stated he did not have documentation of resident #33's medication regimen review after the resident was admitted on [DATE]. Staff member Q was not aware resident #33 had an as needed order for lorazepam which had been in place for more than 14 days. Review of resident #33's medication regimen review, dated 7/30/24 (after the start of the survey), showed there were no concerns or recommendations as of 7/30/24. The pharmacy review failed to identify the presence of an as needed psychotropic medication which had been in place for more than 14 days. Review of resident #33's EHR, accessed on 7/31/24, failed to show any medical provider documentation of the rationale for continuing the as needed lorazepam. Review of the facility's policy titled, Psychotropic Drug Use, not dated, showed as needed psychotropic medications were limited to 14 days. The policy showed the attending prescriber was able to extend the use of as needed psychotropic medications beyond 14 days if there was documentation, by the prescriber, explaining the rationale for continued use.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48262 Based on interview and record review, the facility failed to submit complete and accurate Payroll Based Journal information quarterly, for licensed nursing coverage 24 hours each day to the Centers for Medicare and Medicaid Services. Findings include: Record review of the Centers for Medicare and Medicaid Services report titled, PBJ Staffing Data Report, dated Fiscal Year Quarter 2, 2024 (January 1 - March 31), showed: . Metric . Failed to have Licensed Nursing Coverage 24 Hours/Day, Triggered . Record review of the facility timecards for the following dates: 1/1/24, 2/20/24, 2/27/24, 3/5/24, 3/19/24, and 3/26/24, showed licensed nursing staff in the facility 24 hours each day. During an interview on 7/31/24 at 1:44 p.m., staff member H stated the facility had licensed nursing coverage 24 hours each day. Staff member H stated the facility was able to identify a job code (LPN2) was missing from the file application. Staff member H stated when the facility's information was transferred electronically to the payroll-based journal the system did not recognize the job code (LPN2) and did not report hours worked for employees listed with job code (LPN2).