STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275069	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hot Springs Health & Rehabilitation Center	600 1st Ave N Hot Springs, MT 59845

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48261 Based on interviews and record review, the facility failed to ensure advanced directives were complete for 4 (#s 1, 9, 16, and 30) of 19 sampled residents. This deficiency increased the risk of of the resident's wishes not being met or followed. Findings include: Review of resident #1's POLST, dated 7/8/21, showed a verbal consent by resident #1's guardian. No physical signature by the guardian was present on the form. During a review of resident #9's POLST, dated 4/11/17, showed the physician failed to date the document or complete the provider contact information. During a review of resident #16's POLST, dated 8/25/22, it was found the physician failed to complete the sections labeled, Printed Name of Physician, Date and Time, and Provider Phone Number. During a review of resident #30's POLST, it was found resident #30 had not dated the form, and the physician did not date the form. During an interview on 12/18/24 at 8:44 a.m., staff member B stated the POLST forms are required to be fully completed, including dates. Staff member B stated the facility did not have an Advanced Directives policy. Review of the the Appendix PP, State Operations Manual, for LTC, showed under F578 a facility must, S483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives) . (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. 45448

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER: Hot Springs Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 600 1st Ave N Hot Springs, MT 59845	

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 48261 Based on interviews and record review, the facility failed to complete a PASARR level I or II for 1 (#6) of 19 sampled residents. Findings include: Review of resident #6's EHR reflected no PASARR Level I or II was completed. During an interview on 12/18/24 at 12:10 p.m., staff member B stated resident #6 did not have a PASARR Level I or II since admission to the facility. Staff member B stated she did not know why a PASARR I had not been completed, but one was being completed now. Staff member B stated the facility did not have a policy regarding PASARR Level I's or II's. During an interview on 12/18/24 at 3:23 p.m., NF1 stated when a resident transferred from one nursing facility to another, the new facility should complete their own PASARR Level I, no later than the day of admission, to determine if they are able to provide the resident the services needed.

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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** 45448 Based on interview and record review, the facility failed to implement a comprehensive, resident centered care plan, which identified the resident's physical and psychological needs and wishes, for 1 (#32) of 19 sampled residents. Findings include: During an interview on 12/18/24 at 8:44 a.m., staff member B stated the facility did not have a care plan policy or a significant change policy, and the facility followed the RAI manual. Review of resident #32's electronic medical record showed an admitted [DATE]. Review of resident #32's care plan showed a baseline care plan was initiated on 11/12/24, with revisions made on 11/15/24. No comprehensive care plan had been developed following the resident's admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45448 Based on observation, interview, and record review, the facility failed to update and maintain current individualized care plans, to include when a change to the resident's care occurred, for activity preferences, or ensure staff were aware of how to use/find the individualized comprehensive care plans for use, for 6 (#s 1, 3, 6, 10, 20, and 22) of 19 sampled residents. Findings include: 1. During an interview on 12/17/24 at 2:56 p.m., staff member B said she had been at the facility for [AGE] years, and resident #1's behaviors and care had not changed. Staff member B said all resident care plans were accurate for the residents. Record Review of resident #1's comprehensive care plan showed an admitted [DATE]. Resident #1 had multiple diagnoses identified, including severe intellectual disabilities, bipolar disorder, conduct disorder, unspecified psychosis, unidentified mood disorder, anxiety disorder, and moderate dementia with behavioral disturbance(s). Resident #1 was care planned for behavior of hitting, kicking, scratching, and resistant to cares, with an initiation date of 7/23/2018, and a revision date of 11/14/22. The last documented intervention revision was noted on 11/14/22. Resident #1 was care planned for impaired cognitive function related to bipolar disorder, dementia, and severe intellectual disability, with an initiation date of 7/23/18, and a revision date of 8/26/19. The last documented intervention was noted on 10/2/20. During an interview on 12/18/24 at 10:38 a.m., staff member E said the resident care plans were updated quarterly. Staff member E noted not all residents had activities listed in their care plan. She was working to update all resident care plans with the resident's preferences for activities. During an interview on 12/19/24 at 8:50 a.m., staff member B said the resident care plans were so long and cumbersome, staff did not go by the care plan. The facility staff used the individualized service plan within the electronic medical record. Staff member B said the care plan would be updated by the interdisciplinary team when the resident had a fall, or it would be updated when the resident had a change. Otherwise, the resident care plan was reviewed during the quarterly review period. During an interview on 12/19/24 at 9:23 a.m., staff member M said she had recently returned to work at the facility. Staff member M said she would ask the charge nurse about resident care preferences and needs, because the care plans were not up to date. She was not familiar with the individualized service plans for each resident. 46400 2. Review of resident #22's EMR showed the resident had a diagnosis of obstructive sleep apnea. Review of resident #22's Treatment Administration Record, dated December 2024, showed morning and evening on and off instructions for EPAP 8, PS 3-15 cm H_2O with heated humidity. All administrations were marked as resident refused. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/19/24 at 9:30 a.m., resident #22 stated his CPAP was denied by insurance, and he did not wear anything at night for his sleep apnea. During an interview on 12/19/24 at 9:35 a.m., staff member D stated #22's CPAP was denied due to noncompliance. The resident's CPAP machine had a remote monitoring device that tracked settings and usage. Review of the device data had shown the resident was not consistently wearing his CPAP, and it had therefore been declined by insurance. During an interview on 12/19/24 at 9:50 a.m., staff member K stated the facility went through a lot of channels to get the resident the EPAP since he did not like the CPAP mask. Staff member K stated she asked resident #22 every night she worked, about setting up the EPAP before bedtime, and he always refused. Review of resident #22's comprehensive care plan, with a recent revision date of 10/19/24, failed to show any procedure, resident preference, or refusal related to his sleep apnea equipment. 3. During an observation on 12/16/24 at 3:19 p.m., resident #3 had an orthopedic boot on her left foot. Resident #3 stated it was due to an old broken ankle injury. During an interview on 12/18/24 at 10:10 a.m., staff member H stated the resident wore the orthopedic boot after an old injury and was fearful to get rid of it. During an observation and interview on 12/18/24 at 1:45 p.m., staff member K removed resident #3's boot to reveal the resident's ankle and foot and examine for any skin impairment related to the boot. Staff member K stated the resident slept in the boot and only took it off for showers. Review of resident #3's comprehensive care plan, with a most recent revision date of 4/17/24, showed under the problem section, The resident has acute pain r/t left ankle fracture. The interventions failed to show the resident's use of the orthopedic boot, anxiety around removing the boot, or any concerns for skin impairment related to the resident using the boot. 48261 4. Review of resident #6's EHR Care Plan, with a revision date of 10/17/24, reflected: - [Resident #6] has two open sheared/macerated areas to left buttock secondary to decreased mobility s/p hip fracture, incontinence, rejection of repositioning at times . During an interview on 12/18/24 at 11:23 a.m., staff member K stated resident #6 did not have wounds on her buttocks or maceration during an observation that day. Staff member K stated she observed the resident's buttocks today and found no redness, wounds or maceration. Staff member K stated resident #6 did have maceration quite a while back, but nothing currently. 5. During an interview on 12/16/24 at 3:08 p.m., resident #10 was in his bed and stated he could no longer walk. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/17/24 at 10:13 a.m., staff member H stated resident #10 did not walk and remained in his bed. Staff member H stated resident #10 preferred to stay in his room, in bed, watching television. Review of resident #10's EHR physician history and physical, dated 11/12/24, reflected resident #10 was confined to his bed. Review of resident #10's Care Plan, with a revision date of 3/14/24, reflected: - . The resident is WEIGHT-BEARING - AMBULATION: The resident uses walker for walking. 6. During an interview on 12/17/24 at 10:13 a.m., staff member H stated resident #20 slept most of the days. Staff member H stated she slept more now than she used to, and she was often fed in bed. During an observation and interview on 12/17/24 at 11:50 a.m., staff member J was in resident #20's room feeding the resident, with the bed raised. Resident #20's eyes remained closed during the meal assistance, and staff member J stated resident #20 was, . really declining. Staff member J stated the decline started somewhere between four and six weeks ago. Staff member J stated resident #20 became weaker and started dragging her right foot. Staff member J stated she put the resident to bed because she did not want her to fall. Staff member J stated when resident #20 was walking in the merry walker (specialty walker), she would walk 10 miles a day, wandering in and out of everyone's rooms, now she just slept most of the time and was not walking anymore. During an observation on 12/17/24 at 1:19 p.m., resident #20 was lying half on her bed, with her feet and legs off the bed, and her head was lying against the wall. Staff member J assisted resident #20 back into the bed and offered to get her up. Resident #20 stated she did not want to get up. Resident #20 spoke in nonsensical mumbling that was not understandable. Staff member J checked the resident's brief, and placed a pillow under the resident's head. Resident #20 was grabbing the call light and wrapping it across her body and head. Staff member J stated resident #20 had a severe decline over the past couple of months and was sleeping most of the time and not walking the halls as she had prior. During an interview on 12/17/24 at 1:42 p.m. staff member B stated resident #20 had not used the call light in some time and should not have a call light for safety. Staff member J entered the room and stated resident #20 scares her all the time, and she even puts the pillow over her own head. The call light was removed, and thirty-minute checks were initiated. During an interview on 12/17/24 at 2:56 p.m., staff member B stated resident #20 was up walking last Friday, so she considered the current care plan plan accurate, regardless of what staff on the unit were saying. During an interview on 12/17/24 at 4:45 p.m., staff member L stated resident #20 slept most of the time. Staff member L stated resident #20 used to get up, she would wander the halls with her merry walker, but now she was very difficult to get up, and she required maximum assistance with most tasks, including getting out of bed and eating. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 12/18/24 at 7:35 a.m., staff member K stated she told the CNAs to get resident #20 up this morning. Resident #20 was in the hallway sitting in her merry walker. Resident #20 did not walk or move her merry walker during the observation period. Resident #20 was repetitively mumbling unintelligible words and then fell asleep in the chair, where she remained until the CNAs took her to the dining room, and then assisted 1-1 maximum assistance, assisted her with the meal and her eating it. The CNAs then placed resident #20 back in bed. Staff member K stated the resident really had a decline with her dementia over the past few months. Resident #20 required maximum assistance to get into the bed, and to go from sitting to lying down, in the bed. Review of resident #20's Care Plan, dated 12/17/24, reflected the following: - . PERSONAL HYGIENE/ORAL CARE: [Resident #20] is able to provide her own personal hygiene with cueing. Assist of one staff at times. Revision on: 10/02/2020 - TOILET USE: [Resident #20] requires cueing by one staff for toileting. Revision on: 10/02/2020 - AMBULATION/MOBILITY: Assist: Supervision. Revision on: 02/23/2024 - BED MOBILITY: Independent. Date Initiated: 07/19/2022 - COMMUNICATION: Clear. Date Initiated: 07/19/2022 - Merry walker when up so she can ambulate AD LIB. Date Initiated: 03/13/2024. During an interview on 12/18/24 at 8:44 a.m., staff member B stated the facility did not have a care plan policy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48261 Based on observations and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living for oral care received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene, for 1 (#10) of 19 sampled residents. Findings include: During an observation and interview on 12/17/24 at 3:10 p.m., resident #10 had no dentures in his mouth and stated the dentures were still over on the sink. Resident #10 stated, No one gave them to me or put glue on them, so I haven't had them in today. During an observation and interview on 12/18/24 at 10:11 a.m., resident #10 stated, They (CNAs) haven't put them in yet, they are still on the sink, just need some glue, and (to) give them to me. During an interview on 12/18/24 at 10:20 a.m., staff member H stated the CNAs often did not put his dentures in for a few days to allow his mouth to rest, so he did not get a mouth sore. Staff member H stated the nurse made the decision on who and when residents got dentures. Staff member H stated she was not aware no one had put resident #10's dentures in. Staff member H went to put in resident #10's dentures, and returned stating resident #10 was happy, to have received his dentures and have them put in. Review of resident #10's Care Plan, with a revision date of 6/7/21, reflected: - TEETH: Full Denture: upper, no bottoms. Date Initiated: 06/08/2021 . - Provide mouth care as per ADL personal hygiene. Date Initiated: 06/11/2021 .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48261 Based on observations and interviews, the facility failed to ensure a resident's environment was addressed for safety related to hazards, and the resident had dementia, and misused the call light/cord, and a staff member reported a concern related to the resident's use of a pillow, for 1 (#20) of 19 sampled residents. Findings include: During an observation on 12/17/24 at 1:19 p.m., resident #20 was lying half on the bed, and her feet and legs were off the bed, and her head was lying against the wall. Staff member J assisted resident #20 back into the bed and offered to get the resident up, but she didn't want up. Resident #20 was mumbling, but her words were not clear and comprehensable. Resident #20 was grabbing the call light and wrapping it across her body and her head. Staff member J stated resident #20 had a severe decline over the past couple of months, and the resident was sleeping most of the time, not walking the halls as she had prior. Resident #20 continued to grab the call light cord, mumbling loudly. During an observation and interview on 12/17/24 at 1:27 p.m., resident #20 was in her room, in bed, with the lights off. Resident #20 was still grabbing the call light cord on the wall. Staff member J entered the room, pulled resident #20's pants up, and covered resident #20 with a blanket while resident #20 continued to grab and pull on the call light cord. Staff member J stated, I just don't know what to do with her anymore. Resident #20 continued to gesture or make circles with the cord. She was facing the wall, and continuing to mumble unintelligible words. Staff member J left the room, and went on break, out the back door. During an observation and interview on 12/17/24 at 1:42 p.m., resident #20 continued to pull the call light cord over herself, over her chest, and then her neck. The surveyor immediately notified staff member B, who then entered and observed the behavior. Staff member B removed the call light for safety, and staff member B stated the facility would be implementing thirty-minute checks for the resident, in place of the call light. Staff member B stated resident #20 had not used the call light in some time, and the resident should not have one. Staff member B stated the facility did not usually assess for call light safety, but would use alternate styles of call lights when residents were unable to use a standard button light. Staff member J entered the room and stated, Resident #20 scares me all the time, she even puts the pillow over her head. During an interview on 12/19/24 at 9:15 a.m., staff member B stated the facility did not have a policy or procedure related to call light safety.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45448 Based on interview and record review, the facility physician failed to document resident assessments or physician visits for 4 (#s 1, 4, 6, and 20) of 19 sampled residents. This failure increased the risk of others not having the pertinent medical information available, when needed, to address resident care needs. Findings include: 1. A request was made on 12/17/24 for resident #1's current history and physical. A hospital admission physical, dated 5/5/14, was provided. No current history and physical for resident #1 was located in the resident's electronic medical record. 2. A request was made on 12/17/24 for resident #4's current history and physical, no current history and physical was located in the electronic medical record, or provided by the facility. 48261 3. Review of resident #20's EHR reflected no history and physical had been completed by the physician. Resident #20 was admitted to the facility on [DATE]. A request for the most recent history and physical completed for resident #20 was made, but nothing not provided by the facility. 4. Review of resident #6's EHR reflected no physician history and physical had been completed. Resident #6 was admitted to the facility on [DATE]. A request for the most recent history and physical completed for resident #6 was made, but nothing was provided by the facility. During an interview on 12/17/24 at 2:20 p.m., staff member B said the facility recognized physician visits were not being documented within the resident's electronic medical records. The facility was working to bring physician visit documentation up to date, and currently had about half of the resident history and physicals up to date. Staff member B said the facility did not have current history and physicals for four of those requested.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46400 Based on observation and interview, the facility staff failed to remove expired medications, and allowed the expired items to remain in the same location as the unexpired medications, which increased the risk of misuse. Findings include: During an observation on 12/19/24 at 8:48 a.m., there were the following expired medications located in the facility stock medication cupboard: - Two bottles of Magnesium Chloride, expiration date of 9/2024, - Three bottles of Ferrous Gluconate, expiration date of 5/2024, - One bottle of Iron 27 mg, expiration date of 4/2024, - Three bottles of Meclizine, expiration date of 7/2024, - One bottle of COQ10, expiration date of 8/2024, and - One bottle of Senna Plus, expiration date of 9/2024. During an interview on 12/19/24 at 8:50 a.m., staff member K stated the process of checking on expiration dates and removing medication was supposed to be done by pharmacy as they maintained the medication supply.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45448 Based on observation, interview, and record review, the facility failed to ensure staff followed safe food handling practices and ensure staff used proper hair and beard coverings while meals were prepared and served, which may affect any resident receiving meals or meal services from the staff or kitchen. Findings include: During an observation on 12/17/24 at 12:03 p.m., staff member N had a goatee, which was not covered with a beard net, while N was cooking at the stove. Staff member F was working in the kitchen during meal service, installing new equipment, with no hairnet and beard net. Staff member F had long hair, and a long, full beard. During an observation and interview on 12/17/24 at 12:18 p.m., staff member N was plating resident lunch trays without a beard cover in place. Staff member N said he was to be wearing a beard cover when in the kitchen. Record review of a facility policy, Personal Hygiene Standards, updated June 2021, showed: .a. Hair restraining devices (e.g. hair nets), covering all hair, are worn while on duty. Hair restraining devices are provided for vendors working in the kitchen. b. If a hat is worn, all exposed hair should be covered with a hair net. Hats must be kept clean, and designated for kitchen use only. . k. For those employees with beards, beard guards are worn . 48261

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NAME OF PROVIDER OR SUPPLIER Hot Springs Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 1st Ave N Hot Springs, MT 59845	

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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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33275 Based on interview and record review, the facility governing body failed to ensure the facility implemented and operationalized policies and procedures related to Advance Directives, PASARR Screenings, Care Plans, and Accidents/Hazards. This failure increased the risk of any resident in the facility being negatively affected due to the lack policies and procedures. Surveyors identified deficient practices for resident #s (6, 20, 30, and 32.) of 19 residents sampled, and for these specific residents, the facility did not have policies or procedures for the facility or staff to utilize. Findings include: A review of the policies and procedures during the recertification survey, showed the facility failed to develop and operationalize polices for Advance Directives, PASARR Level One and Two screenings, Care planning, and Accidents and Hazards. Advance Directives: During a review of resident #30's POLST, it was found resident #30 had not dated the form, and the physician did not date the form. During an interview on 12/18/24 at 8:44 a.m., staff member B stated the POLST forms are required to be fully completed, including dates. Staff member B stated the facility did not have an Advanced Directives policy. PASARR Screening: Review of resident #6's EHR reflected no PASARR Level I or II was completed. During an interview on 12/18/24 at 12:10 p.m., staff member B stated resident #6 did not have a PASARR Level I or II since admission to the facility. Staff member B stated she did not know why a PASARR I had not been completed, but one was being completed now. Staff member B stated the facility did not have a policy regarding PASARR Level I's or II's. Developing/Implementing Care Plans: Review of resident #32's electronic medical record showed an admitted [DATE]. Review of resident #32's care plan showed a baseline care plan was initiated on 11/12/24, with revisions made on 11/15/24. No comprehensive care plan had been developed following the resident's admission. During an interview on 12/18/24 at 8:44 a.m., staff member B stated the facility did not have a care plan policy or a significant change policy, and the facility followed the RAI manual. Accidents and Hazards: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hot Springs Health & Rehabilitation Center	600 1st Ave N Hot Springs, MT 59845

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 12/17/24 at 1:42 p.m., resident #20 continued to pull the call light cord over herself, over her chest, and then her neck. Staff member B stated the facility did not usually assess for call light safety, but would use alternate styles of call lights when residents were unable to use a standard button light. During an interview on 12/19/24 at 9:15 a.m., staff member B stated the facility did not have a policy or procedure related to call light safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER Hot Springs Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 1st Ave N Hot Springs, MT 59845	

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48261 Based on interviews and record review, the facility failed to take actions aimed at performance improvement, and after implementing those actions, measure its success, and track performance to ensure that improvements were realized and sustained: failed to identify and develope policies and procedures that direct staff on resident care expectations. This deficient practice had the potential to affect all residents within the facility who required complete medical records for medical review, residents who fall, residents who were cared for without accurate comprehensive care plans, and staff direction for resident care. Findings include: During an interview on 12/18/24 at 8:44 a.m., staff member B said the facility did not have the requested policies and procedures to provide the surveyors. Policies and procedures requested; Advance Directives Policy, PASARR Level I and Level II Policy, Care Plan Policy, Significant Change Policy, and a Call Light Safety Policy. During an interview and record review, on 12/19/24 at 9:11 a.m., staff member B stated the facility did not have any active Performance Improvement plans (PIPs). Staff member B stated she would need to talk to staff member A, as there were no PIPs in the QAPI book. Staff member B stated the facility was aware of the missing physician history and physicals, and working on correcting the issue, but did not have a PIP in place for plan or corrections. Staff member B stated the QAPI team reviewed falls at each meeting, and did not have a PIP, related to falls, for the prevention of falls. Staff member B stated the QAPI team was aware of the inaccuracy of the comprehensive care plans, and was talking about auditing and educating nurses on resolving problems, as needed, with the care plans. Staff member B stated no PIP was completed on the care plan concerns. Staff member B stated the QAPI team was aware of the missing history and physicals completed by physicians in the residents' EHRs. Staff member B stated there was a system change for scanning, and now the scanning was backlogged. Staff member B stated the scanning process needed to be streamlined, so she was talking to IT for help. Staff member B stated there was not a PIP for the EHR inaccuracies or missing information. During an interview on 12/19/24 at 10:23 a.m., staff member A presented a PIP, which was in the book, for falls with fractures. Staff member A stated he had not had time to fill out the Fall PIP components for the first three falls with fractures, until this week. Staff member A stated he had not started another PIP for the 3 new falls with fractures that occurred this past fall, as he intended. During an interview and record review on 12/19/24 at 10:30 a.m., staff member O stated the Fall PIP was not completed and failed to identify the bigger picture (related to fall prevention), follow-up, and document the additional interventions that have been done, like the standup rounds and high-risk meetings on Fridays. Staff member O stated he did not feel the Fall PIP met the requirements for a PIP. Review of the facility PIP, (Draft) Falls with Fracture, dated 6/25/24, reflected three falls with fractures. The following information was missing or completed after the survey began: - Check-In dates: No check-in dates found (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER: Hot Springs Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 600 1st Ave N Hot Springs, MT 59845	

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Goal Statements: To reduce falls with fractures dated 12/17/24 (after the arrival of surveyors) - Identified and Plan: Review of medications that might contribute to falls, review equipment for assistive devices, and in-service staff on fall prevention, dated 12/17/24 (after the arrival of surveyors) - Team Members: No users found - Education of Staff: No assignments found - Attachments: No attachments found Review of the facility's policy, QAPI Plan, dated October 2018, reflected: - .Performance Improvement Process: - .1. QAA Committee evaluates ongoing effectiveness of Performance Improvement Plan (PIP). - 2. QAA Committee sets timetable for follow-up review, if necessary. - 3. QAA Committee determines duration of continued monitoring for sustained improvement. - 4. QAA Committee repeats/returns to PDSA (Plan, Do, Study, ACT) if sustained improvement is not achieved .