STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275073	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faith Lutheran Home	1000 6th Ave N Wolf Point, MT 59201

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 14005 Based on interview and record review, the facility failed to update a resident care plan in a timely manner for elopement for 1 (#31) of 5 residents sampled for elopement, and failed to revise a resident care plan to show effective fall risk interventions following repeated falls with injury for 1 (#50) of 6 residents sampled for falls. Findings include: 1. Review of resident #31's care plan showed the following updates: - 11/21/23, Redirect when wandering ., - 1/31/24, Room was moved to memory care unit locked unit for safety s/t elopement x 2. [sic] - 5/1/24, Hourly visual wellness checks to ensure safety. Review of resident #31's interdisciplinary progress notes showed resident #31 eloped from the facility on 11/8/23, 11/10/23, and 12/1/23. A wander guard was placed on resident #31's wrist on 11/8/23. The care plan was not updated to reflect the elopements until 1/31/24. Review of resident #31's interdisciplinary notes showed he was moved to the memory care unit on 12/26/23, not 1/31/24 as noted in the care plan. During an interview on 5/8/24 at 11:00 a.m., staff member L stated she was not aware they were supposed to do hourly visual wellness checks. 48268 2. During an interview on 5/7/24 at 10:25 a.m., staff member G reported personalized fall prevention strategies would be located on each resident's care plan. Staff member G reported care plan changes and updates were, usually updated by (staff member A, B, or C) I think. During an interview on 5/7/24 at 12:18 p.m., staff member B stated fall risk was assessed on admission for every resident, and if needed, the fall risk would be included in the care plan as a problem category. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/24 at 4:15 p.m., staff member C reported care plan interventions would be updated in the care plan if there was a new indication or event, including a new fall or injury. Staff member C stated, We have fall meetings to go over every fall. Fall meetings were held weekly until recently, and now are held Monday through Friday. Review of resident #50's progress notes showed resident #50 was admitted on [DATE] after a fall with major injuries at home. Resident #50 was identified on the facility's admission assessment to be at high risk for falls. Review of resident #50's progress notes for the period of 5/18/23 through 8/22/23 showed he had four falls between 5/21/23 and 7/13/23, which included fractures. Refer to F689 Accidents and Hazards for resident #50's fall information. Review of resident #50's initial care plan identified fall risk under the heading Problems/Strengths as follows: Potential for Falls related to cognitive impairment and weakness and it is possible fractures are pathological in nature. Strengths: Was admitted to (Facility Name) recovering from (left) hip and wrist. 6/16/23 - Had fall with nondisplaced (fracture) to pelvis; fell [DATE] and fractured (right) hip and wrist. [sic] Review of resident #50's care plan, with a revision date of 8/23/23, showed a total of two active fall interventions listed between 5/18/23 and 8/22/23, although resident #50 had four falls including two falls with major injuries during the same period. The fall interventions listed on the care plan were as follows: - 5/21/23: Anticipate her needs as able, for she may not be able to make her needs known. -6/20/23: Assist with transfers (2 person preferred). Resident does not reliably bear weight and needs a [NAME] lift for transfers (ability varies). [sic] Review of a facility document titled, Falls Prevention and Management, showed the following information: GOALS - . 3. Document all measures used to prevent falls . , POLICY - . 2. Staff will enter interventions in the care plan appropriate for all resident's level of risk . [sic]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on interview and record review, the facility failed to identify a resident's elopement risk or implement interventions following an elopement for 1 (#31) of 4 residents sampled for elopement, and failed to implement, monitor, and modify fall interventions to prevent multiple falls for 1 (#50) of 6 residents sampled for falls. Findings include: 1. During an interview on 5/8/24 at 12:33 p.m., staff member A stated resident #31 had made some requests to leave the facility to visit his friend. Staff member A stated approximately two or three weeks prior to his elopement, resident #31 had gone to the door to leave, but staff stopped him from exiting. Staff member A stated no elopement assessment had been done, prior to his elopement and he was not identified as an elopement risk. The resident did not have a history of eloping and had been at the facility an extended period of time. Review of resident #31's interdisciplinary progress notes on 11/8/23, at 3:07 a.m., showed resident #31 was not in his room. The staff searched the facility and surrounding grounds from 3:00 a.m., until 3:45 a.m. After the initial search, the police, administration, and IT (information technology) were notified. At the time of the elopement, resident #31's BIMS was a 10; moderately impaired cognition. Review of resident #31's last five MDS assessments showed he had a fluctuating BIMS score, and the scores ranged from 9-14. A score of 9 is moderately impaired, and a score of 14 is intact cognition. Review of resident #31's interdisciplinary progress notes on 11/8/23 showed information technology watched the facility video and identified resident #31 leaving the facility at 12:26 a.m., through the front door of the facility. Using this new information, resident #31 was found at 7:00 a.m., in a field six blocks southwest of the facility. Resident #31 was exposed for 6 1/2 hours and transported to the hospital by an ambulance. Review of resident #31's emergency department report, on 11/8/23 at 7:14 a.m., showed resident #31 was hypothermic upon arrival. Resident #31 also had abrasions to his knees. Resident #31 was returned to the facility on [DATE] at 4:04 p.m. During an interview on 5/8/24 at 12:33 p.m., staff member A stated following the elopement a wander guard was applied to his wrist and every one-hour visual checks were done. Review of resident #31's interdisciplinary progress notes on 11/10/24 at 6:51 p.m., showed resident #31 walked out of the 200 wing west door and then re-entered via the activity room door. No changes to the care plan was noted after this elopement attempt. Review of resident #31's interdisciplinary notes on 12/1/23 at 2:39 p.m., Resident walked out of room to the activity door and alarm sounded. The maintenance workers there returned resident to the floor and a CNA assisted the resident further to help back into bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the 12/1/23 through 12/31/23 treatment records showed the staff began monitoring the placement of the wanderguard on 12/24/23. There was no documentation of the monitoring of placement or the function prior to those dates. Review of resident #31's interdisciplinary progress notes on 12/26/23 at 3:07 p.m., showed a delay in transferring resident #31 to the locked memory care unit. 48268 2. During an interview on 5/7/24 at 9:20 a.m., Staff member C reported that resident #50 scored high risk for falls on admission to the facility on [DATE]. Staff member C stated, These (falls) occurred before I came here, so I don't know anything about them. During an interview on 5/8/24 at 10:12 am, staff member A stated that all nursing and CNA staff received fall, abuse, and dementia training annually through an online platform. Review of the Care Area Assessment, completed on 5/24/23, showed resident #50 triggered for Cognitive Loss/Dementia and Falls. Closed record review showed resident #50 was admitted on [DATE] after a fall with major injury at home and fell four additional times in the facility between 5/18/23 and 7/13/23, including two with major injuries. Review of a facility document titled, Resident Fall Incident Report and Post Fall Investigation, completed on 6/16/23, and reviewed by IDT on 6/20/23, showed resident #50 sustained an unwitnessed fall with major injury on 6/16/23 at 7:00 a.m. The document showed the care plan was reviewed on 6/16/23, and showed the following additional fall interventions were implemented at that time: - 1.Get her up and toilet her at start of shift to make sure she does not try to get out of bed by herself. [sic] - 2. Keep bathroom light on her room for better visibility. [sic] The document listed the following information under the heading, Contributing Factors/Action Plan to prevent another injury: - Resident got out of bed by herself and tried to walk. Too weak to remain standing . Resident #50's care plan did not show new fall interventions as per the document above. One fall intervention was added to the care plan in June 2023 was on 6/20/23, as follows: - Assist with transfers (2 person preferred). Resident does not reliably bear weight and needs a [NAME] lift for transfers (ability varies). [sic] (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of facility document titled, Resident Fall Incident Report and Post Fall Investigation, completed on 7/13/23, and reviewed by IDT on 7/18/23, showed resident #50 sustained an unwitnessed fall with major injury on 7/13/23 at 8:00 p.m. The document did not show the care plan was reviewed, and no new care plan interventions were listed. The IDT note stated that the resident was transferred to the hospital on 7/14/23. Resident #50 returned to the facility on [DATE]. No new fall interventions were added to the care plan in July 2023 or August 2023. The document listed the following information under the heading, Contributing Factors/Action Plan to prevent another injury: - Confused. Monitor more closely. [Physician Name] notified orders rec. were to monitor res. clinically t/o night. [sic] The facility failed to implement effective and measurable fall prevention interventions, which had the potential to contribute to resident #50's repeated falls and injuries.