

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275073	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Faith Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>14005</p> <p>Based on observation and interview, the facility failed to ensure privacy during wound measurement and ointment application, for 1 (#25) of 9 sampled residents. Findings include:</p> <p>During an observation on 12/3/24 at 1:30 p.m., resident #25 was seated in a recliner, in the open television room, on the dementia unit. Staff member G did not ask the resident #25 to go to his room but asked if it was alright to do his treatment at that time and place. Resident #25 was in full view of two other male residents. Staff member G pulled the pant legs up and removed resident #25's socks from both legs. Staff member G laid on the floor and used a piece of white paper and traced around the wound on the back of resident #25's heel/lower leg area. Staff member #25 stood up and got a medication cup containing a white colored ointment. Staff member G applied the white ointment to resident #25's legs. After resident #25's socks were reapplied, and the pant legs were pulled back down, staff member G said she did not want to waste the ointment. Staff member G then applied the same ointment to resident #25's bilateral forearms.</p> <p>During an interview on 12/3/24 at 2:10 p.m., staff member C said she would not expect a nurse to complete wound care in the dining room and not in front of other residents.</p> <p>During an interview on 12/3/24 at 5:00 p.m. staff member G said the times for wound care should be changed as resident #25 does not always cooperate with going to his room to receive the treatment in privacy.</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>14005</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with individualized care needs, related to falls and prevention of falls, had identified fall interventions implemented and in place, so care was provided care in a manner to promote the well-being and prevent further falls, for 1 (#51) of 9 sampled residents. Findings include:</p> <p>Review of the facility, undated, fall tracking log, provided by staff member C, showed resident #51 had two falls in October 2024 and two falls in November 2024.</p> <p>Review of #51's nursing notes, dated 10/7/24, showed a request was sent to maintenance to place tread tape on the floor in front of the toilet in #51's bathroom. The nursing progress note showed the fall care plan was updated accordingly on 10/7/24.</p> <p>During review of resident #51's care plan, it was found the only intervention to correlate with the 10/7/24 update was for dycem (non-skip material) to be placed on the resident's wheelchair seat. There was no 10/7/24 update to add tread tapes to the floor in the resident bathroom.</p> <p>Review of resident #51's care plan problems showed resident #51 had potential for falls related to weakness, poor balance and history of falls. Resident #51's care plan, updated on 10/14/24, showed an intervention for tread tape to be placed in front of the toilet, and next to the bed, for improved traction while transferring.</p> <p>Review of #51's nursing notes, dated 11/15/24 showed resident #51 fell while transferring in the bathroom. Resident #51 was attempting to get off the toilet and to his wheelchair. The resident fell to the floor. Review of the care plan following this fall, showed resident #51 did not have any changes made to his care plan for the fall on 11/15/24, to address the root causes of the fall.</p> <p>Review of #51's nursing notes, dated 11/17/24 showed, resident #51 was found on the floor near his bed. Following this fall, there was no interventions added to the care plan to prevent further falls or address the root cause(s) of the fall.</p> <p>During an observation on 12/3/24 at 4:10 p.m., it was found resident #51 did not have the care plan interventions from 10/14/24 implemented. There was no tread tape in front of the resident's toilet and no tread tape in front of the bed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>14005</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with individualized care needs, related to falls and prevention of falls, had identified fall interventions implemented and in place, so care was provided care in a manner to promote the well-being and prevent further falls, for 1 (#51) of 9 sampled residents. Findings include:</p> <p>Review of the facility, undated, fall tracking log, provided by staff member C, showed resident #51 had two falls in October 2024 and two falls in November 2024.</p> <p>Review of resident #51's care plan dated 8/27/24, showed resident #51's toileting transfer needs instructed the staff to provide assistance of one to two people. The care plan also showed, If you assist (name) with transfers, he expects you to do all the work, actually increasing his risk for falling as he has the expectation you are there to do it all and he needs to do nothing . So, staff do not assist and (resident) does all the work, and his safety is maintained.</p> <p>Review of resident #51's nursing notes, dated 10/1/24, showed the resident was having more incontinent episodes, and the staff would need to check on him every two hours.</p> <p>Review of #51's nursing note's dated 10/6/24, showed resident #51 was alone in the bathroom and fell while attempting to transfer from the toilet to the wheelchair. The note showed, the resident slipped and fell on the floor.</p> <p>Review of a fall review investigation for #51, dated 10/7/24, showed the interdisciplinary team reviewed and determined the root cause of the fall. This investigation identified the resident had said the bathroom floor was slick. The fall investigation team recommendation looking into using tread tape for the floor in the bathroom.</p> <p>Review of #51's nursing notes, dated 10/7/24, showed a request was sent to maintenance to place tread tape on the floor in front of the toilet in #51's bathroom. The nurses progress note showed the fall care plan was updated accordingly on 10/7/24. This intervention was not implemented as identified, per review of the care plan.</p> <p>Review of resident #51's nursing note, dated 10/13/24, showed resident #51 slipped and fell off the edge of his wheelchair seat. The note also showed the resident was transferring himself from his wheelchair to his bed and he slipped. The nurses note showed resident #51 had gripper socks on but tread tape was not documented as a preventative measure.</p> <p>Review of resident #51's fall incident report and post fall evaluation form, dated 10/13/24, showed the interdisciplinary team reviewed the fall on 10/14/24. The interdisciplinary team note showed, attempt to place tread tape in front of bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #51's care plan problems showed resident #51 had potential for falls related to weakness, poor balance and history of falls. Resident #51's care plan, updated on 10/14/24, showed an intervention for tread tape to be placed in front of the toilet, and next to the bed, for improved traction while transferring.</p> <p>Review of resident #51's nursing notes, dated 11/15/24 showed resident #51 fell while transferring in the bathroom. Resident #51 was attempting to get off the toilet and to his wheelchair. The resident fell to the floor. Review of the care plan following this fall, showed resident #51 did not have any updates made to his care plan for fall prevention.</p> <p>Review of resident #51's nursing notes, dated 11/17/24 showed, resident #51 was found on the floor near his bed. The nurse's note showed, , it appears as though res. was attempting to transfer from his w/c to his bed and slipped out of his w/c. Resident #51 did not tell the staff how the fall occurred, but said he did not hit his head and that he did not hurt anything. Resident #53 sustained three skin tears during this fall. The nursing notes showed the resident did not hit his head or get any injuries. The facility failed to update the care plan following this fall to prevent further falls and injuries.</p> <p>During an observation on 12/3/24 at 4:10 p.m., resident #51 did not have tread tape in front of the toilet and did not have tread tape in front of the bed.</p>		