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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on observation and interview, the facility failed to provide sufficient privacy between residents with a shared bathroom due to the use of a curtain for 1 (#17) and failed to provide privacy during cares for 1 (#23) of 2 residents sampled for privacy concerns, and failed to ensure the privacy curtains could be closed adequately to provide visual privacy for residents in four rooms, 304, 305, 306, and 308. Findings include: 1. During an interview and observation on 5/7/24 at 8:50 a.m., resident #17 stated she shared a bathroom with the resident in a neighboring room. The shared bathroom had a sliding pocket door entry from each of the resident's rooms. Resident #17 stated the neighboring resident's door was unable to be closed as it would get stuck. A curtain was used in place of the door. Resident #17 stated the door had been broken for over a year. Resident #17 stated she felt this was a privacy concern for her as the neighboring resident was often confused, and she would pull the curtain open without knocking or asking for permission to enter when resident #17 was using the restroom. Resident #17 stated, It bothers me that the lady next door . will never knock. As shown on the MDS, the neighboring resident had a BIMS of 7; severe cognitive impairment. During an interview on 5/8/24 at 7:45 a.m., staff member F stated no maintenance order had been placed for the broken door in the neighboring resident's room. Staff member F stated he had never been shown or told about the broken door in the neighboring resident's room. During an interview on 5/8/24 at 7:54 a.m., staff member A stated the door had been like that for five or six years and the tracks were ruined. Staff member A stated she thought this door was unable to be fixed. During an interview on 5/8/24 at 8:00 a.m., staff member F stated this would make him feel uncomfortable if this was his living situation. Staff member F stated this door could be fixed as he could order new tracks. 14005 2. During an observation on 4/7/24 at 8:47 a.m., staff member M was providing personal care for resident #23. Staff member M failed to pull the privacy curtain around resident #23's bed and failed to close the door. Resident #23's roommate was present during the care. (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

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 05/08/2024
NAME OF PROVIDER OR SUPPLIER: Faith Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 6th Ave N Wolf Point, MT 59201	

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/24 at 8:15 a.m., staff member F stated housekeeping took care of the curtains, and he did not have anything to do with them. When the privacy curtains were closed, a gap was observed between the wall and the edge of the curtain. The arrangement of the rooms would allow for the residents in the bed to observe the care being provided to the other resident. - room [ROOM NUMBER] privacy curtain had an open gap of 37.5 inches. - room [ROOM NUMBER] privacy curtain had an open gap of 42.5 inches. - room [ROOM NUMBER] privacy curtain had an open gap of 50.5 inches. - room [ROOM NUMBER] privacy curtain had an open gap of 32 inches. During an interview on 5/8/24 at 8:20 a.m., staff member L stated she was aware the curtains did not close, but as an agency staff, she did not know who to tell about the problem.

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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 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. 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48268 Based on observation, interview, and record review, the facility failed to provide and consistently document restorative nursing services intended to improve or maintain mobility for 3 (#s 13, 31, and 46) of 9 residents sampled for restorative services. Findings include: 1. During an observation and attempted interview on 5/7/24 at 10:02 a.m., resident #13 was observed in a specialized wheelchair. Mild muscular spasticity and contractures of extremities were observed. Resident #13 was unable to speak due to his diagnosis of receptive and expressive aphasia secondary to cerebral palsy. During an interview on 5/7/24 at 10:17 a.m., staff member G stated restorative exercises were completed for the residents as much as possible. Staff member G stated the CNAs were not always good at completing the documentation in the electronic medical record, but they try. During an interview on 5/7/24 at 10:44 a.m., staff member O stated if the CNA reported a resident had missed their restorative services for the day, they would pass the information on to the next shift nurse or the DON. During an interview on 5/7/24 at 12:20 p.m., staff member C stated the restorative services were no longer located in the restorative binder as stated in the restorative policy, but were now listed under CNA tasks in the electronic medical record. Staff member C stated the policy needed to be updated. During an interview with staff members A and C on 5/8/24 at 9:53 a.m., staff member A demonstrated the restorative task component of the electronic health record system. Staff member A stated if the task was highlighted in red, then it had not been completed. If it was green, it had been completed for the shift. If a task was not completed, the CNAs would let a nurse know. Staff members A and C both stated they were unsure what a yellow highlight on the restorative task would indicate or how the process would work for nurses to follow-up on incomplete CNA tasks. During an interview with staff members A and C on 5/8/24 at 11:55 a.m., Staff member C stated she did not know what Y-1 or N-1 meant on the restorative flow sheet, other than the resident did or did not receive the services. Staff member A reported she did not think there was a way to identify the details of the treatments in the system. Review of resident #13's electronic medical record on 5/8/24, showed a physician's order for restorative services starting on 11/21/22, which remained on the active orders. The order stated PROM (passive range of motion) to B (bilateral) UE/LE (upper extremity/lower extremity) QD (every day). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #13's restorative flow sheet for the period 3/1/24 through 5/1/24 showed the completion of services were indicated with Y-1 or N-1 on the respective shift. There was no legend to define Y-1 and N-1 included on the flow sheet. There were no treatment details including, length of treatment time, number of repetitions, pain, limitations with treatment, or if the resident was unavailable or refused. There was a minimum of 7 missed opportunities for restorative services, on 3/7/23, 3/14/23, 3/15/23, 3/28/23, 4/16/23, 4/17/23, and 5/1/23. Confirmation of additional missed opportunities was not possible without a legend for N-1. 14005 2. Review of resident #31's physicians order, dated 5/31/22, showed resident #31 was discontinued from outpatient occupational therapy. The orders showed the resident was to continue the [NAME] Voice Treatment (LSVT) exercises with contact guard assistance and gait belt four times per week. Review of resident #31's care plan showed resident #31 was to do the Restorative nursing exercises: LSVT-big exercises 4X/week independently in (resident's) room; Ask him and document when completed; prompt him and remind him to do . [sic] During an interview on 4/8/24 at 9:20 a.m., staff member N stated she had been at the facility about six months. Staff member N stated she had not provided restorative nursing for resident #31. Staff member N stated resident #31 will sometimes walk, but the steps taken are weak and his feet cross over each other. Staff member N stated she mostly feeds resident #31 his meals and may take him to some activities. Staff member N stated there are no restorative exercise programs being offered to resident #31. During an interview on 4/8/24 at 11:00 a.m., staff member L stated she does not complete any restorative exercises with resident #31. Staff member L stated she is unaware of any formal program. Staff member L stated there are no guides or directions for the staff on restorative exercises on the memory care unit. Staff member L stated she would not know where to document restorative exercises. Staff member L stated she has not helped resident #31 with any exercise program. Staff member L stated resident #31's legs are weak. 50245 3. During an interview on 5/7/24 at 10:05 a.m., resident #46 stated she would like to walk more and she had noticed she had become weak. Resident #46 stated, I wish I got a bit more mobility. During an interview on 5/7/24 at 4:14 p.m., staff member G stated he was expected to provide restorative cares or ROM once per shift based on the Care Plan Intervention Task. Staff member G stated a task had not been completed and was due if it had a red outline around the box [the intervention]. Review of resident #46's electronic medical record showed resident #46 had an order for ROM dated 2/14/24, that read, Ambulate to tolerance w/gaitbelt and wheelchair TID. [sic] However, the CNA restorative task showed it was to be completed twice daily.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50245 Based on observation, interviews, and record review the facility failed to provide food at a palatable temperature for 3 (#s 4, 20, and 46) of 21 sampled residents. The failure had the ability to affect all residents who eat food from the kitchen in the facility. Findings include: During an observation and interview on 5/6/24 at 4:44 p.m., the food had been sitting unattended on the steam table with the lids on, and staff member E had just entered the kitchen after running food to another facility. Staff member E was asked to take the temperature of the food on the steam table. The temperature of the chicken in the steam table at that time was 123.9 degrees Fahrenheit. During an observation on 5/6/24 at 4:59 p.m., there were no insulated plate bases located under the plates that the food was served on. During an observation and interview on 5/6/24 at 5:02 p.m., six trays had been prepared with food to be shortly served in the dining room. The plates had insulated dome covers on the top of the plates, but did not have warmers on the bottom of the plates. Staff member D was asked to take the temperature of these foods. At the lowest temperature, the carrots were 112.9 degrees Fahrenheit, and the highest temperature was 125 degrees Fahrenheit. Staff member D said to staff member E, .the temps are dropping on the vegetables. During an interview and observation on 5/6/24 at 5:07 p.m., staff member D stated the plates were usually warmed before food was placed on them. Staff member D showed a plate warmer that was located in front of the steam table. During an interview on 5/6/24 at 5:31 p.m., staff member E was asked if the plate he was about to put food on was warm to the touch. Staff member E grabbed the plate and stated, No. During an interview on 5/7/24 at 9:14 a.m., resident #20 stated, No one warms up the veggies - they are consistently cold. Someone there doesn't know how to use the microwave! During an interview on 5/7/24 at 10:05 a.m., resident #46 stated the hot food is lukewarm. During an interview on 5/7/24 at 2:56 p.m., staff member H stated she was aware of resident complaints about cold food. During an interview on 5/8/24 at 11:00 a.m., resident #4 stated, No, it's just a little bit warm (when he was asked if the food was hot).

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 50245 Based on observations, interview, and record review, the facility failed to monitor and control the temperature of the personal resident room refrigerators, and ensure food safety with the use of them, per the facility policy, for 2 (#12 and #17) of 3 sampled residents with refrigerators. Findings include: 1. During an observation and interview on 5/8/24 at 10:28 a.m., the temperature of the refrigerator in resident #12's room was 55 degrees Fahrenheit. Resident #12's refrigerator had seven cartons of milk present. Resident #12 stated the facility managed the refrigerator temperatures and cleanliness. Staff member I stated she was unsure of what a safe refrigerator temperature should be. 2. During an observation on 5/7/24 at 8:50 a.m., resident #17's personal refrigerator was at a temperature of 50 degrees Fahrenheit and in the Danger Zone as indicated on the thermometer located inside the refrigerator. Resident #17 stated the facility provided cleaning and temperature monitoring and maintenance of the refrigerator. During an interview on 5/7/24 at 2:46 p.m., staff member G stated he was unsure, but thought the night staff managed the temperature of the personal refrigerators. During an interview on 5/7/24 at 4:57 p.m., staff member B stated housekeeping managed the temperature and cleanliness for the personal refrigerators in the residents' rooms. During an interview on 5/8/24 at 9:17 a.m., staff member I stated her supervisor usually managed the personal refrigerators. However, due to an illness, the supervisor was out of the office this week, so staff member I was expected to check the temperatures of the residents' personal refrigerators. During an observation and interview on 5/8/24 at 10:17 a.m., the refrigerator #17's room did not have a thermometer in it. Resident #17 stated the thermometer was gone because staff member I had taken it out of the refrigerator as staff member I thought the thermometer was broken. Policy: This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators . - 1. Dormitory-sized refrigerators are allowed in a resident's room under the following conditions: - a. The refrigerator is inspected by maintenance personnel and deemed safe prior to use and upon routine inspections. - b. The refrigerator maintains proper temperature . . 2. Environmental Services staff shall record refrigerator temperatures weekly on a temperature log. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- a. A thermometer shall remain in the refrigerator. It shall be calibrated prior to use and periodically thereafter. - b. Temperatures will be at or below 41 degrees F . According to the U.S. Department of Agriculture, the Danger Zone is considered to be the temperature range from 40 to 140 degrees Fahrenheit where bacteria can grow very quickly (U.S. Department of Agriculture, 2020). During an interview on 5/8/24 at 10:40 a.m., staff member I asked, What should the temperature be under? Review of facility policy titled, Resident Refrigerators, dated 5/2018, showed: - . 1. Dormitory-sized refrigerators are allowed in a resident's room under the following conditions: . b. The refrigerator maintains proper temperature . - . 2. Environmental Services staff shall record refrigerator temperatures weekly on a temperature log . . b. Temperatures will be at or below 41 degrees F . Reference A temperature of 40 F should be maintained in the refrigerator. In contrast to freezer storage, perishable foods will gradually spoil in the refrigerator. Spoilage bacteria will make themselves known in a variety of ways. The food may develop an uncharacteristic odor, color and/or become sticky or slimy. Molds may also grow and become visible. Bacteria capable of causing foodborne illness either don't grow or grow very slowly at refrigerator temperatures. An appliance thermometer should always be used to verify that the temperature of the unit is correct. U.S. Department of Agriculture. (2020, October 19). How Temperatures Affect Food. Retrieved from Food Safety and Inspection Service: https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/how-temperatures-affect-food#5