STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275080	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cooney Healthcare and Rehabilitation	2555 E Broadway Helena, MT 59601

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 32998 Based on interview and record review, the facility failed to ensure nursing staff followed professional standards of practice for identifying a resident's change in condition, for the assessment and implementation of supplemental oxygen for a resident's saturations of 75%, for the assessment and implementation of interventions for non-verbal indicators of pain, for the assessment of intake and output for weight loss, monitoring of vital signs, and accuracy of, per physician orders, and monitoring of bowel movements for abnormalities, for 1 (#1) of 8 sampled residents. These cumulative failures, which occurred over multiple shifts and included various staff disciplines, contributed to the residents negative outcomes identified in F684 - Quality of Care, and the Immediate Jeopardy announced on 5/2/24. Findings include: During an interview on 5/1/24 at 9:43 a.m., staff member F stated non-verbal signs of pain are grimacing, inability to talk, agitation, and a resident may not stay seated, and would be moving up and down. Staff member F stated the process for a change in condition was to talk to the nurse right away and report any changes observed for a resident. No other symptoms of pain were identified by staff member F, who provided ADL cares for the residents, to include when pain symptoms may be exhibited. During an interview on 5/2/24 at 1:03 p.m., staff member C, who provided skilled nursing services, stated when a resident falls, the process was to assess the resident for injuries, assess vital signs, start neurological checks, and check for blood thinners. Staff were to continue to observe if there are no injuries, and the resident may be sent out to the hospital if a change in the baseline of the resident occurred. Staff member C stated the process was to assess the resident on the floor, before moving the resident to another location. Staff member C stated after the initial resident fall/change of condition assessment, it is an ongoing process of observation. Staff member C stated oxygen was to be applied if resident saturations were less than 90%. When resident #1's oxygen dropped on 4/21/24, he did not have oxygen placed, and his saturations were in the 70's. During an interview on 5/2/24 at 1:06 p.m., staff member G stated the process for falls, or a change in resident condition, was to assess resident vital signs and compare the vitals to their baseline, assess for injuries, check range of motion, check level of consciousness, and then get the resident up off the floor, using a lift if necessary. Then staff would make the notifications necessary. Per staff member G, the resident would not be moved from the floor until the nursing assessment was completed. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/2/24 at 2:00 p.m., staff member K stated changes in condition were reported to the nurse. Staff member K stated agitation, anger, confusion, and inability to sit still could be signs of pain. Resident #1 displayed anger and agitation, confusion at times, and he would often stand and sit back down repeatedly. Refer to F684 - Quality of Care for more information on pain. Review of resident #1's Progress Notes, dated 4/16/24 - 4/21/24 failed to show ongoing assessments of the resident's condition related to orientation, pain, vital signs, and oxygen needs. Review of resident #1's MAR, dated 4/1/24 - 4/10, and 4/16/24 to his discharge date , for vital signs, showed the physician order was for the resident to have his vitals assessed two times daily. When reviewing the documentation for resident #1's vital signs there were no fluctuations in the results for any of the vitals, on any of the days, for any of the shifts. The lack of fluctuation, in some capacity, is not typical due to day to day changes with a resident's status and medical complexities. contributing to changes. A review of the online document Preventing copy-and-paste errors in EHRs, published in July of 2021, Publication, Quick Safety, Issue 10, showed: The use of the copy-and-paste function (CPF) in health care provider ' s clinical documentation improves efficiencies, however CPF can promote . internal inconsistencies, error propagation, and documentation in the wrong patient chart, potentially putting patients at risk. https://www.jointcommission. org/-/media/tjc/newsletters/quick-safety-10-update-7-19-21.pdf. Review of resident #1's Neurological Evaluation, dated 4/21/24, showed: - The resident was lethargic - Oriented to person only - Blood pressure 77/64; oxygen saturations 75% on room air. There was no evidence the nursing staff applied oxygen to the resident for his low saturations - Pupils equal Review of resident #1's MAR, dated 4/1/24 - 4/30/24 showed the resident had not had pain medication from 4/16/24 to 4/21/24. The resident had a repair of a fractured hip due to a fall on 4/10/24. The medical record failed to show ongoing monitoring of non-verbal indicators for pain. During an interview of 4/30/24 at 1:30 p.m., staff member N stated the resident often wandered, but did not express pain. He was more disoriented on his return from the hospital after his hip fracture. She stated he would be sitting, and would get up, and then sit back down again, quite frequently. Resident #1 would also get upset with staff to include during care, and he had sundowners. Staff member N was not able to state if pain contributed to any of the behaviors exhibited by the resident. Review of resident #1's care plan, dated 4/16/24 - 4/21/24 showed the following new interventions: - Nutrition; Routine RD (registered dietician) evals and recommendations (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Pain Management related to right hip fracture; pain medications as ordered, evaluate level of pain, evaluate characteristics and frequency/pattern of pain, evaluate the need for pain medication prior to therapy, and utilize non-pharmacological interventions. - Behavioral; monitor for verbally abusive behavior and psychosocial well-being Review of resident #1's meal intake documentation showed: - 12 out 36 opportunities for meal intake were not documented - The resident had a significant decrease in meal intake from 4/17/24 to 4/20/24 Review of resident #1's Nutritional Assessment, dated 4/18/24, showed the resident had an admission weight of 110 lbs, had erratic intake, fair appetite, was alert and confused, and had a nutritional supplement added to his daily intake due to being underweight. The assessment did not address the weight loss timely, prior to it becoming a severe loss. Review of resident #1's bowel elimination documentation for April, 2024, showed the size, but not the descriptive color. On the resident's 4/21/24 admission to the local hospital, after a change in condition, the resident was noted to have black tarry stools. Refer to F684 for more information for the resident's 4/21/24 admission status. The resident's medical record did not include information on tarry stools prior to his discharge. During an interview on 4/30/24 at 1:40 p.m., staff member O stated the resident participated in therapy daily, and he often had problems sleeping. When discussing pain, she stated she would look at a resident's body language, facial expressions, grimacing, if the resident was stressed, clenching teeth, or repositioning his/herself often. She stated if she noticed pain, she would document it in the resident progress notes, and every time care was provided she would watch for pain symptoms. If pain occurred, she would document on the MAR if medications were utilized. Staff member O stated resident #1 did not eat much, and he was given a protein shake. Staff member O did not realize the resident had a severe weight loss. He also liked breakfast, but not lunch or dinner. Staff member O stated resident #1 had cellulitis, history of alcohol use, smoking, and he would lose his breath often (due to breathing issues), and he could not chew well. She stated he did not show pain well, but he regularly tried to get up and out of his chair, and would sit back down. She stated she did not notice any changes from the resident's baseline status over his stay. Staff member O was not been aware of the resident having tarry stools prior to his discharge on 4/21/24. Staff member O stated if a resident was in respiratory distress, the physician would be given oxygen to increase saturation to at least 90%, and the physician would be contacted. Staff member O was aware resident #1 had respiratory deficits. During an interview on 5/1/24 at 9:43 a.m., staff member F stated he was to document bowel movements in size, but not color. Staff member F stated if there was blood in the stool or abnormal color, then he would report it to the nurse. A review of the current Federal and State CNA Training and Competency testing for Montana (not all inclusive), included: - Basic nursing skills (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Understanding behaviors of cognitively impaired residents - Bowel and Bladder management - Recognizing and reporting resident changes to the supervisor - Taking and recording vital signs accurately Although some staff voiced the ability to carry out, or know, the proper process for resident care related to pain, falls, and changes in condition, the standards were not all upheld during #1's stay at the facility. Refer for F684 Quality of Care for more information on resident #1.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32998 Based on interview and record review, the facility failed to provide quality care services to a skilled care resident admitted for rehabilitation services and nursing care; failed to identify a severe weight loss totaling 21.8% and implement nutritional interventions for prevention of further loss; failed to obtain, document, and assess vital signs as ordered by the physician; failed to follow physician orders; and failed to assess and identify behavioral care needs, to include pain, and ensure documentation was included in the EHR; Prior to his ER transfer, nursing staff failed to sufficiently assess and address a significant change in condition and provide oxygen for a decline in respiratory status, for 1 (#1) of 4 sampled residents. Resident #1 expired the same day he was transferred to the local hospital after his change in condition. On [DATE] at 9:30 a.m., the facility administrator was notified of an Immediate Jeopardy situation related to resident #1, and deficient practices related to F684-Quality of Care. The Severity and Scope of the Immediate Jeopardy was identified to be at the level of J, and upon removal of immediacy, lowered to a G. Findings include: During an interview on [DATE] at 2:18 p.m., NF1 stated resident #1 weighed 106 pounds when he discharged from the hospital on [DATE], and was admitted to the facility. NF1 stated the resident weighed 88 pounds when he was weighed at the hospital on [DATE], after he trasnferred from the facility, after a change in condition. NF1 stated there was a CNA in a different room who heard resident #1 yelling for help on [DATE]. The resident had a fall, and the staff got the resident up and in his bed. The resident was reported to lose consciousness. When staff assessed the resident after the fall, the resident's airway was adjusted, and the resident was sent to the hospital for further assessment and care. When the resident arrived at the emergency department, he was immediately diagnosed with sepsis, and his vital signs were not good. NF1 stated the resident had been on oxygen at the facility but had kept taking it off. NF1 stated the resident showed signs of pain such as teeth clattering, his behavior, and moaning. NF1 stated resident #1 had lost 20 pounds in 30 days, his abdomen was concaved (sunken in), and it was very noticeable that the resident had lost a significant amount of weight. NF1 stated when the resident arrived at the hospital, he was incontinent of stool, and the stool was black and tarry. During an interview on [DATE] at 3:31 p.m., staff member E stated the dietician was in one time per week and weights were reviewed. Staff member E stated the dietician either met with her or emailed concerns to her to ensure the residents were getting the right nutrition. During an inteview on [DATE] at 10:37 a.m., staff member D stated protein shakes were added to resident #1's MAR for nutritional supplement. Staff member D stated she meets with the IDT to review weights. Staff member D stated Nutritional Assessments were completed 7 to 14 days following admission. Staff member D stated resident #1 was gone by the time she came to the facility to complete an assessment. Resident #1's first Nutritional Assessment was completed on [DATE]. The resident's first admission was on [DATE] and re-admission was on [DATE] (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's After Visit Summary, from [Hospital Name] for his stay from [DATE] to [DATE], showed he weighed 110 pounds, oxygen saturations were 91%, and his respirations were 18. He had no diet restrictions, and it showed he, may return to regular diet. The resident was prescribed an antibiotic during his stay, Ciproflaxacin HCl, 500 mg tablet, by mouth, one in the morning and one in the evening. The resident also had lisinipril 20 mg tablet, by mouth, once a day, for his blood pressure management. Clobetasol was ordered for the treatment to his legs due to skin concerns. Review of resident #1's [Hospital Name] After Visit Summary, dated [DATE], showed the resident weighed 110 pounds on discharge from the hospital. Review of resident #1's weight record, dated [DATE], showed he weighed 110# on his admission to the facility, which correlated with the hospital weight. Review of resident #1's facility admission nursing assessment, dated [DATE], showed: - Alert and oriented times four - Weight was 110 lbs - Regular diet with ability to eat independently - One person assist with use of sit to stand lift for transfers, and walker/wheel chair for mobility - Respiratory effort 20 per minute - 96% on room air - Pain level three Review of resident #1's nutritional assessments showed he did not have an assessment completed during his facility stay from [DATE] to his first discharge on [DATE]. He also did not have a nutritional assessment or interventions put in place for his severe weight loss over the short period of time he was at the facility, in an attempt to prevent further loss, or in an attempt to identify potential causes of the loss. Review of resident #1's facility meal intake record, dated [DATE] through [DATE] showed the following: - Nine out of 24 times the resident consumed ,d+[DATE]% of meals. - Five out of 24 times the resident consumed ,d+[DATE]% of meals. - Four out of 24 times the resident consumed ,d+[DATE]% of meals. - Four out of 24 times the resident consumed ,d+[DATE]% of meals. - Two out of 24 times the resident refused his meals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 12 times of missed documentation for meal consumption. - The resident had significant decreased meal intake between [DATE] through [DATE] after treatment for a fractured hip. The resident was not in the facility from [DATE] until readmission on [DATE]. 33275 Review of resident #1's weight records, from the [Hospital Name] showed he weighed 88 lbs, which was a severe weight loss prior to his first hospital admission, which occurred on [DATE]. Review of resident #1's facility nursing notes showed he had a fall on [DATE], and he was sent out to the hospital after the fall. Details included the resident fell backwards and landed on the floor. The resident refused to bear weight on his right lower extremity. The resident was assisted to the wheelchair by two staff. The resident was sent to the emergency room via EMS at 3:15 p.m. The nursing notes did not show if an assessment of injuries was completed prior to the decision of assisting the resident to his wheel chair. Review of resident #1's fall assessment, dated [DATE], showed the cause of the fall was related to his mobility, pain, weight, and contributing factors, oxygen use or problems with his breathing or respiratory status Review of resident #1's facility admission records showed he was admitted to the skilled nursing home on [DATE], after he discharged from the local hospital. Review of resident #1's Power of Attorney showed he had a living will and he, .desired to receive treatment for comfort or to alleviate pain ., and there were no exceptions noted. Review of resident #1's Physician orders, for his admission to the facility, showed he was to receive Occupational, and Physical therapy five times per week for 12 weeks, and Speech Therapy three times per week, for four weeks. Review of resident #1's physician standing orders showed oxygen ,d+[DATE] liters per minute per nasal cannula or a mask if oxygen saturations were less than or equal to 89%, and staff were to follow facility protocol related to oxygen use and maintaining his oxygen saturation above 89%, and his diet was documented to be a regular diet. Review of resident #1's physician progress notes showed he was not seen by the physician during his nursing home stay from [DATE] to [DATE]. Review of resident #1's admission nursing assessment, dated [DATE], showed: - Alert and oriented to person only - Weight was 112.6 lbs - Regular diet with ability to eat independently (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- One person assist with use of sit to stand lift for transfers, and wheel chair for mobility. The resident was using a walker prior to his fall on [DATE]. - Respiratory effort 17 per minute - 93% on oxygen via nasal cannula - pain level seven Review of resident #1's Medication Administration Record (MAR), dated [DATE]-[DATE], showed the resident was monitored for behaviors including name calling, inappropriate language, excessive wandering or elopement attempts, every shift. Staff were to document adverse behaviors in the progress notes. This monitoring was noted to be discontinued on [DATE]. There was no additional monitoring for behaviors, and how his behavior may be related to pain due to his hip fracture, after the resident returned to the facility on [DATE]. The resident was not at the facility between [DATE] and [DATE] Review of resident #1's facility Pain Assessment, Post Incident, completed on [DATE] at 3:07 p.m., and 3:59 p.m., showed the resident was resistive to cares, restless, had fluctuations in mental functioning, aggressive and he had a loss of interest. Weight loss was not noted. He had a pain level marked as 9 and 9.5, with a level of 10 being the highest. He was not able to verbalize his pain, and pain was marked as being mild. The pain was new, and it was due to a fall, per the note. The Plan of Care showed he had satisfactory pain managment. Review of resident #1's [Hospital Name] record, for his admission on [DATE], after his fall with hip pain, showed he was moderately demented. He had been discharged a week prior for lower bilateral lower extremity cellulitis and bilateral lower extremity venous stasis dermatitis. At the time of his discharge, he was ambulating freely and interacting with staff, and he was then discharged to the nursing home. The notes showed he stated a man shoved him to the ground, and he landed on his butt and immediately had pain in his right bottock and hip. He was provided Dilaudid for his pain management and admitted for surgical fixation of the right intertrochanteric hip fracture. Information provided from the resident was limited due to dementia and he was pleasantly demented. The record showed he had a weight of 83 pounds and 5.3 ounces, which was a severe loss over the prior seven days. His oxygen saturations were 83% and respirations 16. The resident was placed on 2 liters of oxygen by nasal cannula, had a regular diet, and he had a do not resuscitate in place for his advance directives. Within the same notes, dated [DATE], the record showed resident #1 did not understand that he fractured his femur. His weight remained just over 83#. With his oxygen on, his saturations remained above 90%, except for one occasion on [DATE] and he was at 87%, and he had just been changed to room air. Under the Musculoskeletal section, documentation showed he had, Pain with any motion of the right hip. Tenderness to palpation of the right hip. Review of resident #1's [Hospital Name] Case Classification note for his surgery, dated [DATE], showed he continued his regular diet, and he had two pressure injuries to his left and right heel, both hospital aquired. He had acute hypoxemic respiratory failure for a diagnosis and edema. The resident was in the hospital for his hip fracture from [DATE], and he discharged on [DATE], back to the nursing home. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's [Hospital Name] records and medications showed on ,d+[DATE], ,d+[DATE], and [DATE], he received: - oxyCODONE, 5 mg table, as needed every four hours, for moderate to severe pain. He received the medication twice on [DATE] and [DATE], and once on [DATE], and then he was discharged . - He received RisperiDONE in the evening and at night, for agitation, on ,d+[DATE] and [DATE]. - Tylenol was prescribed at 650 mg tablets, while awake, which he received three times on [DATE] and four times on [DATE], and on the day of discharge, he received two doses. - On [DATE], both his right and left heel developed a pressure injury, which were hospital aquired, and first noted at 11:35 a.m. that day. - The resident was discharged with the availablity to receive oxyCODONE 5 mg tablet for pain management and amoxicillin for the treatment of an infection. - The resident was discharged back to the nursing home on [DATE]. Review of resident #1's SNF Progress Note, dated [DATE], which is the day after he was readmitted to the nursing home following his fractured hip surgery, showed he had acute hypoxemic respiratory failure and fracture of his right hip. He was on Augmentin due to pneumonia in left lower lobe, which was started [DATE]. The note showed the family decline oxygen use due to the tubing being a trip hazard. This was not documented in the resident's medical record. The resident's lasix was held, and due to his poor appetite and need to monitor edema, daily weights were ordered. The resident was to have vitals taken two times daily with his blood pressure monitored. There were no open areas on the resident's buttocks, but neither the heels, nor the weight loss, were noted. He did have schedule narcotics for pain, per the documenation. The resident was found wandering and defecating in a garbage can, and staff did not notice a baseline change. The Medications section of the note showed he was to have oxyCODONE 5 mg tablet by mouth every four hours, as needed, for moderate pain. Under the Vitals section, the notes showed, There is no height or weight on file to calculate BMI. Review of resident #1's facility Weights and Vitals Summary, from [DATE] to [DATE] showed the resident had no documented weights between [DATE] to [DATE] and [DATE] to [DATE]. The resident was admitted to the facility on [DATE], went to the hospital on [DATE] and returned to the facility on [DATE] following repair of a fractured hip. Review of resident #1's [Hospital Name] History and Physical, dated [DATE], showed the resident's hospital admission weight was 83 pounds. When resident #1 arrived at the emergency roiagnom on [DATE] he weighed 88 pounds. Review of resident #1's MAR, dated [DATE]-[DATE], showed nursing were to assess the resident for pain using the numeric scale every shift. The resident had oxyCODONE 5 mg every four hours as needed for pain with a start date of [DATE], following re-admission after surgical repair of the right hip fracture. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's facility Admission and Baseline Care Plan/Summary, dated [DATE], showed the resident had a pain level of seven, he was oriented to person only, and had oxygen via nasal cannula at 2 L/min. Review of resident #1's Pain Assessment-Post Incident, dated [DATE], showed the resident was unable to answer questions due to cognitive or communication deficit Review of resident #1's facility Progress Notes, dated [DATE] -4 /,d+[DATE], showed the resident was readmitted back to the facility on [DATE]. The progress notes had no information related to admission, orders, cognitive status, or pain level. Review of resident #1's facility Fall report, dated [DATE], showed the resident was found on the floor in his room by staff. The resident fell backwards out of his wheel chair, was drowsy, oriented to person only, and had skin tears to right elbow, forearm skin tear, and left finger. There were no bumps or lacerations to the resident's head. The resident was unable to describe what happened related to his fall. Review of resident #1's facility Neurological Evaluation, dated [DATE], showed: - The resident was lethargic. - Oriented to person only. - Blood pressure ,d+[DATE]; oxygen saturations 75% on room air. There was no evidence nursing staff applied oxygen to the resident to improve the saturation level. - His pupils were equal. Review of resident #1's Pain Assessment-Post Incident, dated [DATE], showed the resident was unable to answer the questions due to his cognitive or communication deficit During an interview on [DATE] at 3:38 p.m., staff member C stated resident #1 fell out of his wheel chair on [DATE], he was drowsy, and he had a decreased level of consciouness. Staff member C stated the resident had not had any visible injuries to his head. Staff member C stated the resident's speech was slow. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's emergency room hospital record showed he was admitted at 8:56 a.m., on [DATE]. The Chief Complaint was documented as Shortness of Breath, PT arrived by ems from [Facility] for unwitnessed fall, no thinners, unknown loc, c/o sob. 70's RA for ems. Hx DNR and comfort measures, recent femur fx repair. The resident was found on the ground at the nursing home and was found to have a pulse oximetry of 70% on room air. His advanced directives were reviewed, and he had no CPR and comfort focused treatment only. The resident's blood pressure was documented to be ,d+[DATE], his pulse 89, respirations were 7, and his weight was 88 lbs and 2.9 oz. He was in significant respiratory distress. The resident was found to have, Equisite tenderness to palpation with decreased bowel sounds, and Mottled skin of bilateral lower expremities. The resident was confused and disoriented. While in the emergency room , the staff provided the resident HYDROmorphone (Dilaudid) for pain at 9:19 a.m., 9:38 a.m., and 10:09 a.m., and when the residents comfort was discussed at 9:53 a.m., he was still Uncomfortable which is why the 10:09 a. m. dose was provided. Due to the resident's status and decline, he was provided end of life care. The Procedures section showed he was clearly uncomfortable and in pain upon arrival. Review of resident #1's emergency room Provider Note, dated [DATE], showed the resident was in the ER for nine hours before passing away. During an interview on [DATE] at 1:30 p.m., staff member N stated residents receiving skilled services have their vitals taken two times each shift, unless the person is sick, then it may be more. If the resident's blood pressure is out of range, the employee taking the vitals should immediately report the concern to the charge nurse, and then a recheck is done in 30 minutes. She stated sometimes, a check is done right away, just to verify accuracy. Staff member N considered a low blood pressure to be ,d+[DATE], and a high blood pressure to have a systolic over 140. When discussing pain symptoms, staff member N stated she would observe pain in a resident who displayed a fever, moaning, making noises (made by resident), crying, or wandering. Staff member N stated resident #1 did wander, but she did not feel he expressed non-verbal pain indicators or symptoms. She said when he returned from the hospital, after his hip fracture, he was walking fine and would get up and forget about the hip fracture as he was more disoriented. Staff member N was not sure of resident #1's baseline pain level, as to help identify if he had pain symptoms not being addressed, but stated he sundowned, so his behaviors increased at night, and he would get upset at times, but this was not related to pain. Staff member stated resident #1 was kept out in the social area of the facility (sitting area between the units) due to his behaviors, as to help keep him occupied. Then if the resident was attempting to wander or standing up and down in his chair, staff would notice, and try to stop him. Staff member N did not identify the wandering, getting up/down in his wheelchair, sundowning behaviors, or getting upset with others were possible indicators of pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275080	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cooney Healthcare and Rehabilitation	2555 E Broadway Helena, MT 59601

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 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32998 Based on interview and record review, facility nursing staff failed to provide supplemental oxygen for a resident's saturation level of 75%, with standing orders to apply oxygen two liters via nasal cannula for saturations less than 89%, for 1 (#1) of 8 sampled residents, and the resident had a decline in status and was sent to the ER. Findings include: During an interview on [DATE] at 3:38 p.m., staff member C stated when she assessed resident #1 after his fall on [DATE], he was drowsy, had a decreased level of consciousness, and slow speech. During an interview on [DATE] at 1:03 p.m., staff member C stated oxygen would need to be applied if oxygen saturations were less than 90%. Review of resident #1's Fall documentation, dated [DATE] at 7:37 a.m., showed the resident had an unwitnessed fall in his room. The resident fell backwards out of his wheel chair, was drowsy, was oriented times one, had skin tears to his elbow, forearm skin tear, and left ring finger. No bumps or lacerations were noted to the resident's head. The resident was unable to describe what happened. Under immediate action taken the resident's vital signs were taken, skin tears were cleaned. The resident was not taken to the hospital at that point, but was later transferred to the hospital. Review of resident #1's facility Fall Assessment-Post Incident and Neurological Evaluation failed to show oxygen was applied to the resident when his saturations were 75%. 33275 A review of resident #1's [Hospital Name] emergency room hospital record showed he was admitted at 8:56 a.m., on [DATE]. The Chief Complaint was documented as Shortness of Breath, PT arrived by ems from [Facility] for unwitnessed fall, no thinners, unknown loc, c/o sob. 70's RA for ems. Hx DNR and comfort measures, recent femur fx repair. The resident was found on the ground at the nursing home and was found to have a pulse oximetry of 70% on room air. His advanced directives were reviewed, and he had no CPR and comfort focused treatment only. The resident's blood pressure was documented to be ,d+[DATE], his pulse 89, respirations were 7, and his weight was 88 lbs and 2.9 oz. He was in significant respiratory distress. The resident was found to have, Equisite tenderness to palpation with decreased bowel sounds, and Mottled skin of bilateral lower extremities. The resident was confused and disoriented. While in the emergency room , the staff provided the resident HYDROmorphone (Dilaudid) for pain at 9:19 a.m., 9:38 a.m. , and 10:09 a.m., and when the residents comfort was discussed at 9:53 a.m., he was still Uncomfortable which is why the 10:09 a.m. dose was provided. Due to the resident's status and decline, he was provided end of life care. The Procedures section showed he was clearly uncomfortable and in pain upon arrival. During an interview on [DATE] at 2:18 p.m., NF1 stated the resident had been on oxygen at the facility but had kept taking it off.