

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/03/2024
NAME OF PROVIDER OR SUPPLIER  Cooney Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261</b></p> <p>Based on observations, interviews, and record review, the facility failed to report an incident of potential abuse for two residents (#s 1 and 2) to the State Survey Agency, or the resident's representative, of 5 sampled residents. This failure increased the risk of other events occurring related to the two residents, due to preventive measures not being taken, and one resident displayed overly attentive behavior towards males. Findings include:</p> <p>Review of a complaint filed on 8/20/24 reflected the following concern:</p> <p>- Staff member C gave staff member F report, explaining resident #1 had, .wandered into, [Resident #2's] room and climbed into bed with him. [Resident #2] was very mad and went after [Resident #1] with his wheelchair. Staff member C stated she was not going to report it because it's too much work.</p> <p>During an interview on 10/3/24 at 10:50 a.m., resident #2 was sitting in the common area talking to staff and residents in the common area. Resident #2 appeared pleasantly confused. Resident #2 stated he did not remember anyone in his room or someone getting into bed with him.</p> <p>During an observation and interview on 10/3/24 at 11:11 a.m., resident #1 was sitting in a wheelchair in the hallway. Resident #1 was confused and unable to respond appropriately to questions. Resident #1 appeared to be clean and her mood appeared happy.</p> <p>During an interview on 10/3/24 at 1:15 p.m., staff member A stated the reportable process would include sending the social worker to investigate, nursing staff were to assess the resident(s) and to put accusations of abuse, neglect, misappropriation, or exploitation in the state Bounds (abuse reporting) system. Staff member A stated he had started in late August and could not explain why the incident with resident #1 wandering into resident #2's bed .cuddling was not reported. Staff member A stated he was not made aware of the incident involving resident #1 and resident #2.</p> <p>During an interview on 10/3/24 at 5:38 p.m., NF2 stated she had not received any calls from the facility about any incidents happening with resident #2. NF2 stated she was not happy, because she never gets calls from the facility.</p> <p>(continued on next page)</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/4/24 at 11:24 a.m., NF1 stated she received a call from the facility on 10/3/24 reporting the incident of resident #1 climbing into bed with a male resident. NF1 stated she was flabbergasted, upset, and did not understand why the facility took six weeks to find out the incident happened.</p> <p>Review of resident #1's EHR Progress notes, dated 8/5/24-8/6/24, reflected resident #1 .was found cuddling with room [ROOM NUMBER] in the recliner. Taken back to her room and continue to monitor. and . resident has been up and down all noc. Masturbating a lot. She took her brief off and urinated on the bed than came out to the common area walking. She is steady on her feet.</p> <p>Review of resident #1's Care Plan: Safety/Vulnerability, with a revision date of 7/29/24, showed the following:</p> <ul style="list-style-type: none"> <li>- . [Resident #1] is at risk for abuse r/t dementia and being vulnerable and exhibiting overly affectionate behaviors toward other male residents.</li> </ul> <p>Review of the facility's policy, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated September 2022, reflected the following:</p> <ul style="list-style-type: none"> <li>- .2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:</li> <li>- a. The state licensing/certification agency responsible for surveying/licensing the facility .</li> </ul>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>50245</p> <p>Based on interviews and record review, the facility failed to ensure staff were performing cares within their scope of practice and without necessary training, for 1 (#12) of 3 sampled residents. This practice increased the risk of negative outcomes for those residents who received care from staff member C. Findings include:</p> <p>During an interview on 10/3/24 at 10:44 a.m., staff member F stated staff member C was able to fire staff, work on the floor, create the schedule, and perform duties as the wound specialist.</p> <p>During an interview on 10/3/24 at 1:09 p.m. staff member H stated staff member C had been a wound nurse, floor nurse, manager and scheduler, all without RN supervision.</p> <p>During an interview on 10/3/24 at 3:15 p.m., staff member C stated she did make determine measurements and recommendations about a resident's wound, on her own.</p> <p>Review of resident #12's, A Weekly Wound Review, dated 9/22/24, reflected measurements of a left ear pressure ulcer, at a stage II, with measurements of 0.5 cm x 0.25 cm x 0.1 cm. The report reflected:</p> <ul style="list-style-type: none"> <li>- % Epithelial 25-50;</li> <li>- % Grandulation 25-50;</li> <li>- % Slough 0-25;</li> <li>- % Eschar/Necrotic 0-25;</li> <li>- Drainage Type - Serosanguinous - Yes;</li> <li>- Wound Edges - Intact - Pink.</li> </ul> <p>This wound assessment was signed as completed by staff member C, who was not a Registered Nurse.</p> <p>Review of the Montana Code Annotated 37.8.1 showed the defined scope of practice in the state of Montana for a Licensed Practical Nurse:</p> <p>- (8) (a) Practice of practical nursing means the performance of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing procedures. The practice of practical nursing uses standardized procedures .These services are performed under the supervision of a registered nurse or a physician, naturopathic physician, physician assistant, optometrist, dentist, osteopath, or podiatrist authorized by state law to prescribe medications and treatments .</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Montana Code Annotated 37.8.1 showed the defined scope of practice in the state of Montana for a Registered Nurse:</p> <p>- (9) Practice of professional nursing means the performance of services requiring substantial specialized knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing theory as a basis for the nursing process. The nursing process is the assessment, nursing analysis, planning, nursing intervention, and evaluation in the promotion and maintenance of health, the prevention, casefinding, and management of illness, injury, or infirmity, and the restoration of optimum function .</p> <p>During an interview on 10/3/24 at 3:20 p.m., staff member B stated, without proper training and supervision, she was unaware an LPN was not allowed to complete wound assessments and was unable to be the wound care nurse</p> <p>The facility allowed a LPN to assess, evaluate, plan, and implement resident care plans and respond to resident's needs, specifically related to wound care, which was outside her scope of practice.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>50245</p> <p>Based on observations, interviews, and record review, the facility failed to provide oversight to ensure the nursing scope of practice was being followed appropriately for 1 (staff member C) of 5 staff sampled, and failed to uphold disciplinary action for an LPN license on probation, and there were restrictions on the license staff member C. Findings include:</p> <p>During an interview on 10/3/24 at 10:44 a.m., staff member F stated they had concerns about the care of the residents at [Facility Name] and some of the management was teaching the staff to provide a substandard quality of care. Staff member F gave an example where they described an incident where an overweight resident fell , and CNAs were instructed to get a resident off the floor, without checking the resident's vitals first and without using a lift. Staff member F also stated there was an incident where they had tried to contact staff member C and was later told staff member C did not answer because the phone was in a lake. Staff member F had called due to an emergency at that time. Staff member F stated staff member C was able to fire staff, work on the floor, create the schedule, and was the wound care specialist.</p> <p>During an interview on 10/3/24 at 1:09 p.m. staff member H stated he was concerned about the residents' care at [Facility Name]. They stated, There was about a year and a half straight where this place was run just a little strange. People were being neglected. Wounds were not being changed. Anytime someone brought something up, they would be squeezed out (off the schedule). Staff member H stated staff member C was extremely aggressive towards other staff at times. Staff member H stated staff member C's license was on suspension related to alcohol abuse. Staff member H stated they knew this information because staff member C told everyone, including the residents. Staff member H stated, . you start to ask questions after a while . Staff member H stated, There is so much chaos internally. Our morale as staff is horrible. Staff member H stated staff member C had been a wound nurse, floor nurse, manager and scheduler, all without (RN) supervision. Staff member H stated staff member C gave narcotics without supervision. Staff member H stated they had been asked to sign for a narcotic they had not seen staff member C physically give. Staff member H also stated, The wounds were not done very much. Staff member H described the wounds as ooey and gooey when he would assess the wounds, as the dressings were not being changed often enough, in the past.</p> <p>During an interview on 10/3/24 at 3:15 p.m., staff member C stated she does the wound dressings, wound staging (determining severity), and wound measurements on her own.</p> <p>Review of the Montana Code Annotated 37.8.1 showed the defined scope of practice in the state of Montana for a Licensed Practical Nurse:</p> <p>(8) (a) Practice of practical nursing means the performance of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing procedures. The practice of practical nursing uses standardized procedures .These services are performed under the supervision of a registered nurse or a physician, naturopathic physician, physician assistant, optometrist, dentist, osteopath, or podiatrist authorized by state law to prescribe medications and treatments .</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>b. [Staff member C] shall have her supervisor(s) submit quarterly reports to the Board office addressing [staff member C's]: (1) compliance with the terms of this Stipulation; (2) adherence to nursing standards of practice; and (3) adherence to policies and procedures at the facility .</p> <p>c. [staff member C] shall submit monthly updates to the Department regarding her employment status. The notification shall include whether she is working as an LPN and, if she is working as an LPN, her place of employment, title, duties, the name(s) of her supervisor(s).</p> <p>Refer to F726 Competent Nursing Staff related to staff member C and failing to have the necessary competencies and training for wounds.</p>		