STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275106	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intermountain Health Holy Rosary Hospital	2600 Wilson St Miles City, MT 59301

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 - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 14005 Based on observation, interview, and record review, the facility failed to identify root causes for falls, update care plans with interventions to prevent falls, and to decrease the risk for recurring falls, for 3 (#s 3, 271, and 109) of 5 sampled residents. Findings include. 1. Review of resident #3's nurse progress notes, dated 5/24/23, showed resident #3 frequently slept in his recliner. The nurse progress note also showed resident #3 was found on the floor after an unwitnessed fall. Resident #3 was sent to the emergency room and was diagnosed with a hip fracture. Review of resident #3's nurse progress notes, dated 6/1/24, showed resident #3 was readmitted to the facility following the hip fracture. Review of resident #3's care plan on 6/5/24, showed the care had not been updated with new interventions following his hip fracture and change in status. During an interview on 6/5/24, at 9:42 a.m., staff member C said the facility reviewed the falls every Thursday during the fall meetings. Staff member C said the care plans did not get updated until that meeting. Staff member C said, on 5/24/24 resident #3 got his feet tangled in the blankets, which caused the resident to fall out of bed. Staff member C said resident #3's care plan was updated to include the risk of getting his feet tangled in the blanket. Staff member C was unable to identify the date when the update was made to the care plan regarding the blankets. Staff member C said the update was probably done on 5/30/24 when the fall meeting occurred. Staff member C could not identify what changes had been made to the care plan following resident #3's hip fracture. 2. Review of resident #271's nurses notes showed: - 5/14/24 - Resident #271 was reaching down and fell out of his wheelchair. - 5/17/24 - Resident #271 fell on to his knees while working with the therapy department. - 5/31/24 - Resident #271 was found in his room on the floor. The nurses note showed resident #271 was found on 5/30/24 at 6:24 p.m., by his bed. Resident #271 told the staff that he slid from his wheelchair. (continued on next page)

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 - Some	During an observation and interview on 6/5/24 at 3:15 p.m., resident #271 said he has had one or two falls. Resident #271 said there was a reacher for him, but he did not use it. Resident #271 said the wheelchair scooted away from him (when transferring). Resident #271 was observed sitting in a regular wheelchair with his left arm in a sling. Resident #271 was observed propelling himself around the facility. The wheelchair brake handles were short and not easily reached by the resident who had his left arm in a sling. Review of resident #271's care plan showed fall interventions dated 4/11/24, with no updates since then to address root causes of the falls on 5/14, 5/17, and 5/31/24. Fall interventions included: - Long reach grabber - Staff to monitor and assist resident to reposition in Broda chair - Resident to work with PT 4/16/24, Occupational Therapy still pending - Staff to provide resident #271 with a puffer call light that is easier to activate - Dycem under and on top of his ROHO cushion in his Broda chair to decrease the chances of slipping out of the chair - Resident to wear sling for left arm to assist with support so he is not leaning to the left in Broda chair - Resident has non-elevating standard footrest with strap at the back to help keep feet in place 3. Review of resident #109's nurses notes, dated 5/31/24, showed resident #109 was found down on the floor. Resident #109 fell out of her Broda chair. Resident #109 was assessed in the emergency room after the fall and returned to the facility. Review of resident #109's post fall huddle, dated 5/31/24, showed the facility identified factors that could have contributed to the fall. The interventions identified were to lay the Broda chair back, so it was not setting upright, place the call light closer to the resident, and the resident would use oxygen. Review of resident #109's care plan showed the last care plan update for falls was done on 5/3/24. The facility failed to update the care plan to include interventions identified on the post fall huddle form. The care plan was not updated after the fall on 5/31/24 to include interventions to reduce the risk for further falls. During an interview on 6/6/24 at 9:47 a.m., staff member B stated the nurses were supposed to complete the post fall huddle every time after a fall to identify the cause of the fall. Staff member B said it was difficult to get the fall system working well due to having interim nurses from an agency. Staff member B said the team mets every Thursday and updated care plans once a week.