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	02/27/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 48268 Based on observation, interview, and record review, the facility failed to provide education and information to the residents or responsible party on the risks and benefits of psychotropic medication, so they were able to make an informed decision, and the facility did not have documentation to show the resident/responsible party consented to the use of the medications, for 3 (#s 6, 18, and 39) of 18 sampled and supplemental residents. Findings include: a. During an interview on 2/24/25 at 3:02 p.m., resident #6 stated she was on, . a lot of medicine for my mood and my anger. Review of resident #6's medication orders showed sertraline 25 mg daily, with no associated diagnosis listed. The medical record failed to show education was provided on the use or risks and benefits of the psychotropic medication in order to make an informed decision on the use of it. b. Review of resident #18's medication orders showed citalopram 10 mg daily, with the associated diagnosis of anxiety. The review of the medical record failed to show the resident or the resident's representative received education related to the use or risks, and benefits of the psychotropic medication in order to make an informed decision on the use of it. c. Review of resident #39's medication orders showed trazodone 50 mg daily at bedtime, with the associated diagnosis of insomnia due to other mental disorder. Review of resident #39's medical record failed to show the resident or the resident's representative was provided education related to the use and risks and benefits of the psychotropic medication in order to make an informed decision on the use of the medication. During an interview on 2/26/25 at 9:57 a.m., staff member B stated consents were supposed to be obtained for all psychotropic medications used within the facility, which would show the resident/responsible party was aware of the risks/benefits of the medications. A request was made on 2/26/25 for the written consents for the above listed residents, but none were received by the end of the survey period.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 14005 Based on observation, interview, and record review, the facility failed to maintain a safe environment, free from elopements, for 4 (#s 16, 17, 18, and 24), and the facility failed to provide an environment free from accidents and hazards for 1 (#42) of 18 sampled and supplemental residents. This deficient practice had the potential to adversely affect the well-being and safety of all residents in the facility. Findings include: 1. Review of the Facility Reported Incident, dated 8/31/24, showed resident #24 left the Residential Living side of the facility, and the resident eloped into the hospital. The facility identified the alarm between the two areas had not been activated. During an interview on 2/25/25 at 11:17 a.m., staff member B said resident #24 eloped because the alarm on the dining room doors, which led to the hospital, were not activated. Staff member B said staff were educated to ensure the alarm was set to alarm if the door to the hospital was opened. But, no system was put in place to monitor the status of the alarm. Staff member B said if the alarm was not set properly, it increased the risk for residents to elope to the hospital. During an interview on 2/26/25 at 12:35 p.m., staff member B said the facility did not have an elopement assessment for the residents in the Residential Living area and none of the residents had been assessed for elopement risk. Staff member B said the facility was working on developing an elopement assessment for the Residential Living area. Staff member B said resident #s 16, 18, and 24 were at risk for eloping. During an interview and observation on 2/26/25 at 5:24 p.m., staff member I said she did not know how to identify the residents at-risk for elopement. She said, I would think the residents at risk for eloping would be the ones who hang around the door. Staff member I said the only resident she knew of who was an elopement risk was resident #24. Resident #24 was observed near the front exit door during this interview. During an interview on 2/26/25 at 5:28 p.m., staff member J said there were two residents at risk for elopement, resident #s 17 and 24. During an interview on 2/26/25 at 5:40 p.m., staff member K identified two residents who were at risk for wandering and eloping. She identified residents #s 17 and 24. During an interview on 2/27/25 at 7:47 a.m., staff members A and B said the elopement book was not current or updated. Staff member B said it would not surprise her if there were seven residents identified in the elopement binder. Staff member A said the staff should know which residents were at risk for eloping by looking at the care plan or the C.N.A. assignment sheet. 2. During an observation on 2/24/25 at 4:34 p.m., there was an unsecured work bench in the activity room, which was accessible to the residents. On the bench, and within easy reach of residents, were the following items: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Double-edged wood working hand saw, - T-handle screwdriver, - Numerous bottles of paint; and, The work bench contained two easy sliding drawers which contained: - Large tin snips, - [NAME] grips, - Utility knife with a sharp blade, - Wire cutters, - Pipe wrench, - Drill and drill bits - Ball peen hammer, - Hacksaw During an observation and interview on 2/24/25 at 4:30 p.m., resident #42 was sitting in her wheelchair near the work bench in the activity room. Resident #42 stated, That looks like a lethal weapon. Resident #42 was pointing to the double-edged wood saw. During observations on 2/25/25 at 8:30 a.m., and 2/26/25 at 11:50 a.m., the activity room contained a work bench which was not locked. The tools were accessible with some tools on top of the bench and the rest of the tools in the drawers. The tools and paints were not secured, and the drawers were not locked. The activity room was also not locked. During an interview on 2/25/25 at 11:27 a.m., staff member E said when maintenance needs to do repairs in the Residential Living area, the staff bring a tool chest to the area, or a handheld pouch of tools, depending on the size of the job. Staff member E said none of the maintenance tools are left where residents could access them. During an interview on 2/25/25 at 3:19 p.m., staff member G said the activity doors are always open, and all the residents can go in and out any time they want. Staff member G said she was not sure how the safety of the tools was maintained. Staff member G said all the tools could be accessed by any resident right now because the tools were just sitting out on the bench or in the drawers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 2/25/25 at 3:31 p.m., staff member A was in the activity room looking at the resident work bench. Staff member A said the tools, which belonged to a resident, were put away and the drawers under the bench were closed when the tools were not in use. During this observation, the screw drivers, the T-handled screwdriver, and the metal ruler were readily accessible. The drawers were closed, however the drawers opened easily, and the listed tools were all accessible to residents.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 14005 Based on observation, interview, and record review, the facility failed to review the risks and benefits of using a transfer rail, attached to the bed, for the resident and failed to obtain an informed consent prior to the installation of the transfer rail for 1 (#48) of 14 sampled residents. Findings include: During an observation and interview on 2/25/25 at 9:13 a.m., resident #48 stated, I didn't ask for them (bed rail assist bars). One was here when I got here, and they put the other one up. They have been there. They don't bother me, they are just there. Resident #48 stated, There is something on them and maybe I can figure them out later, as she was touching the grab bars and jabbing at them with her fingers. Resident #48 said, The facility does not want us to fall out of bed. Resident #48 was observed turning herself in bed independently without using the grab bars, and then sat straight up in bed without assistance. Resident #48 was able to maintain her unassisted upright position during the 10-minute interview. Review of resident #48's initial Bed Rail/Assist Bar Evaluation, dated 1/23/25, showed the bed rails would be used for positioning, bed mobility, and security. There was no safety assessment to include resident #48's physical ability, strength, and physical size as part of this evaluation. During an interview on 2/26/25 at 12:58 p.m., staff member B said the facility did not have consents for the grab bars for resident #48 or any of the other residents using grab bars. Staff member B said the Bed Rail/Assist Bar Evaluation was used to identify the appropriateness of grab bars and the resident's desire for grab bars. Staff member B said the grab bars were made specifically for each bed and therefore safety assessments were not necessary. Entrapment risk related to her physical ability and her underweight status of 86 pounds was not included on the evaluation form.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 14005 Based on interview and record review, the facility failed to implement a consistent antibiotic stewardship program, including infection surveillance and mapping, to identify trending of the locations of infections. This deficient practice increased the risk of a negative outcome related to residents taking antibiotics for infections and increased the incidence of adverse events associated with infections throughout the facility. Findings include: During an interview on 2/27/25 at 9:19 a.m., staff member L stated infections and antibiotic use were not tracked for June of 2024. Staff member L said the facility completed the McGreers criteria for tracking infections, but it was not completed in June of 2024. Review of the facility's Infection Control binder showed a lack of infection mapping and line listings for the last year from January of 2024 through January of 2025. Staff member L said, The facility isn't so large that I couldn't just identify if there were trends related to specific infections. Staff member L was unable to identify any areas of infection trends. Staff member L said she just started in December of 2024, and she was just learning what needs to be done.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 14005 Based on interview and record review, the facility failed to provide COVID-19 vaccinations for 3 (#s 6, 17, and 35) of 14 sampled residents, and failed to document staff declinations and education regarding the COVID-19 vaccine for 2 (staff members M and N) of 2 sampled staff members. Findings include: During an interview on 2/25/25 at 3:31 p.m., staff member L said the facility pharmacy did not carry the COVID-19 vaccine. Staff member L said the facility could take the residents to the local drug store or the other local clinic, and the residents could get their vaccinations there. Staff member L said keeping the vaccinations at the facility was cost-prohibitive, and would cost the residents over three hundred dollars per vaccine. During an interview on 2/26/25 at 10:29 a.m., staff member H said the facility used to carry COVID-19 vaccines but stopped getting them due to waste. Staff member H said the vaccine could be ordered in pre-filled syringes which would help contain cost for the residents. Staff member H said the cost and billing would be the responsibility of the billing department and was unsure if residents would be able to use their Medicare Part D benefits. Staff member H said billing was not the reason vaccinations were not being given at the facility. During an interview on 2/27/25 at 7:47 a.m., staff member A stated there was no education provided to staff regarding the COVID-19 vaccine. There was also no documentation of consent or declination of the COVID-19 vaccine. Review of a facility document titled, Moderna COVID-19 Vaccine, dated 7/18/24, showed resident #6 requested to receive a Moderna COVID-19 vaccine in July of 2024. Review of resident #6's EHR failed to show the COVID-19 vaccine was provided to the resident as of the start of the survey. Review of resident immunization records for resident #17 and 35 showed the residents were currently waiting to get the COVID (vaccine). IP currently working on getting COVID vaccines. A review of the facility's policy titled,Vaccination Administration Policy, revised 2/24/23, did not address staff requirements for COVID-19 vaccinations. A request was submitted on 2/26/25 for COVID-19 vaccine education and consent or declination documentation for staff members M and N. None were received prior to the end of the survey.