

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Laurel Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  820 3rd Ave Laurel, MT 59044	
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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>48268</p> <p>Based on interview and record review, the facility failed to provide a written notice of the reason for a facility-initiated transfer to the resident or the resident's representative, for 3 (#s 7, 37, and 111) of 18 sampled residents. Findings include:</p> <p>1. During an interview on 12/18/24 at 9:59 a.m., staff member D stated the nursing staff were responsible for telling the residents the reason for their transfer to the hospital. Staff member D stated, The nurses let me know, and I complete the transfer form for the medical record. Staff member D stated she did not know the facility was required to provide written notification of transfer to the residents, stating, The form is in the computer, and they can always ask for a copy, but I didn't know we were supposed to provide a copy before they transferred.</p> <p>During an interview on 12/18/24 at 2:12 p.m., staff member E stated when a resident was transferred to the hospital, the nurses completed a transfer report form for the hospital staff, and told the resident or their representative of the reason for transfer, but no paperwork was completed or provided to the resident or their representative.</p> <p>During a telephone interview on 12/18/24 at 3:40 p.m., NF2 stated the staff, . usually call or text me when (resident #7) is taken to the hospital, but I have never received anything in writing.</p> <p>Review of resident #7's nursing progress notes showed resident #7 was transferred to the hospital on 10/6/24 for an acute change in medical condition.</p> <p>Review of a facility document, titled, RESIDENT NOTICE OF TRANSFER OR DISCHARGE, dated 10/6/24, showed, Verbal upon transfer/discharge to the hospital typed on the signature line, which was designated for the resident or resident's representative, without additional clarifying information added to show who was notified.</p> <p>41652</p> <p>2. During an interview on 12/19/24 at 10:08 a.m., resident #37 stated he had been hospitalized three times in the past year. Resident #37 stated he did not remember getting any paperwork from the facility regarding the reason for his transfers to the hospital.</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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/19/24 at 11:15 a.m., NF1 stated she had not received any documentation from the facility regarding the reason for resident #37's transfers to the hospital for care.</p> <p>Review of resident #37's EHR showed he was transferred to the hospital for care on 2/28/24, 4/2/24, 6/2/24, 7/14/24, and 10/10/24. The EHR failed to a written notice of the reason for the transfers was given to the resident or the resident's representative at the time of, or immediately after, the transfer.</p> <p>3. During an interview on 12/19/24 at 10:10 a.m., resident #111 stated she had been hospitalized in late November of 2024. Resident #111 stated she did not remember getting any paperwork when she went to the hospital in November of 2024.</p> <p>Review of resident #111's EHR showed the resident was transferred to the hospital for care on 11/29/24.</p> <p>During an interview on 12/19/24 at 10:55 a.m., staff member B stated the floor nurse who transferred the resident to the hospital was supposed to provide the written notice of the reason for the transfer to the resident and the resident's representative. Staff member B stated staff member D was supposed to give the resident and their representative a copy of the written notice describing the reason for the resident's transfer.</p>

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>48268</p> <p>Based on interview and record review, the facility failed to provide the required bed hold notice to the resident or the resident's representatives prior to, or timely after, a transfer, for 3 (#s 7, 37 and 111) of 18 sampled residents. Findings include:</p> <p>During an interview on 12/18/24 at 9:59 a.m., staff member D stated she was responsible for completing the bed hold agreements when nursing staff notified her a resident was transferred to the hospital. Staff member D reported no written documentation of the bed hold agreements were provided to the residents or their representatives.</p> <p>During an interview on 12/18/24 at 2:12 p.m., staff member E stated when a resident was transferred to the hospital, the social services department was responsible for completing the bed hold agreement.</p> <p>1. During a telephone interview on 12/18/24 at 3:40 p.m., NF2 stated the staff, . usually call or text me when (resident #7) is taken to the hospital, but I never received anything in writing. NF2 stated, I don't know anything about that, what is that exactly . when asked by the surveyor about bed hold agreements, stating, No, I have never gotten anything like that.</p> <p>Review of resident #7's nursing progress notes showed resident #7 was transferred to the hospital on 10/6/24 for an acute change in medical condition.</p> <p>Review of a facility document, titled, BED HOLD AGREEMENT, dated 10/7/24, showed, Verbal upon transfer/discharge to the hospital typed on the signature line designated for the resident. No additional clarifying information to show who was notified, or which facility staff member provided the notification.</p> <p>41652</p> <p>2. During an interview on 12/19/24 at 10:08 a.m., resident #37 stated he had been hospitalized three times in the past year. Resident #37 stated he did not remember getting any paperwork from the facility regarding bed hold information.</p> <p>During an interview on 12/19/24 at 11:15 a.m., NF1 stated she had not received any documentation from the facility regarding bed hold information when resident #37 was transferred to the hospital for care.</p> <p>Review of resident #37's EHR showed he was transferred to the hospital for care on 2/28/24, 4/2/24, 6/2/24, 7/14/24, and 10/10/24.</p> <p>3. During an interview on 12/19/24 at 10:10 a.m., resident #111 stated she had been hospitalized in late November of 2024. Resident #111 stated she did not remember getting any bed hold information when she went to the hospital in November of 2024.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Review of resident #111's EHR showed the resident was transferred to the hospital for care on 11/29/24.</p> <p>During an interview on 12/19/24 at 10:55 a.m., staff member B stated nursing was supposed to give the resident bed hold notice paperwork and then staff member D did the follow-up. Staff member B stated she was unaware staff member D was not providing copies of the bed hold notice information.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>51111</p> <p>Based on interview and record review, the facility failed to ensure all controlled substance medications were accurately administered, accounted, and documented for 4 (#s 24, 27, 38, and 109) of 4 sampled and supplemental residents receiving physician ordered controlled substances. Findings include:</p> <p>Review of the Facility Reported Incident, submitted to the State Survey Agency, dated 9/27/24, showed an investigation was initiated and completed by the facility in response to an internal audit of medication reconciliation for controlled substances.</p> <p>Review of the Facility Reported Incident investigative file, provided by the facility on 12/18/24, showed the following:</p> <ul style="list-style-type: none"> <li>- Three licensed nursing staff members (NF4, NF5, and NF6) were suspended during the investigation and all three were subsequently terminated following completion of the investigation by the facility.</li> <li>- The information identified during the investigation was submitted to the Montana State Board of Nursing.</li> <li>- Residents #24, 27, 38, and 109 were investigated by staff to determine if the errors with controlled substances and medication administration errors affected or caused harm to them. There were no observed or reported instances of physical or psychosocial harm found to have occurred to them.</li> </ul> <p>Review of a facility investigative document showed separate recorded incidents in which:</p> <ul style="list-style-type: none"> <li>- NF4 gave the wrong dose of morphine 15 mg to resident #109,</li> <li>- NF4 did not count resident #38's lorazepam 1 mg in the controlled substance book,</li> <li>- NF5 gave the wrong dose of hydromorphone 2 mg to resident #27 and the wrong dose of oxycodone 15 mg to resident #24,</li> <li>- NF5 did not count resident #24's oxycodone 5 mg in the controlled substance book,</li> <li>- NF6 gave the wrong dose of hydromorphone 2 mg to resident #27, and</li> <li>- NF6 did not count resident #24's oxycodone 15 mg and resident #38's lorazepam 1 mg in the controlled substance book.</li> </ul> <p>Review of #24, 27, 38, and 109's resident care plans showed diagnoses with goals and interventions associated with the their diagnoses. The failure of NF4, NF5, and NF6 to correctly administer medications to the residents increased the risk of deterioration to the individuals and their medical conditions and potential well-being. The care plans showed:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Resident #38's care plan, revised date 6/20/24, showed a diagnosis of Huntington's chorea with communication problems due to impaired cognitive function and impaired thought processes, and an intervention of the use of anti-anxiety medication due to anxiety from Huntington's chorea.</p> <p>- Resident #24's care plan, revised date 12/13/23, showed a diagnosis of dementia with impaired cognitive function and thought processes along with chronic pain history and an intervention to administer analgesic medication as per orders.</p> <p>- Resident #109's care plan, dated 8/26/24, showed a diagnosis of right foot surgery and osteomyelitis requiring use of pain medication therapy, with an intervention to administer analgesic medications as ordered by physician, and to review every shift and as needed for pain medication efficacy.</p> <p>- Resident #27's care plan, revised date 7/31/24, showed a problem of chronic pain and neuropathy, with an intervention of administering analgesia as per orders, and giving 30 minutes prior to treatments or care.</p> <p>Review of a facility document labeled, [NF5]- June Audit of Narcotics, showed:</p> <p>- Medications were noted to be incorrectly documented on various dates.</p> <p>- Medications were signed out in the MAR but not the controlled substance log book on 5 instances, and medications were signed out in the controlled substance book but not on the MAR on 6 instances.</p> <p>Review of a facility document labeled, [NF4]- June Audit of Narcotics, showed:</p> <p>- Medications were noted to be incorrectly documented on various dates.</p> <p>- Medications were signed out in the MAR but not the controlled substance book on one occasion, and medications were signed out in the controlled substance book but not the MAR, on four occasions.</p> <p>Review of a facility provided document, Inservice Education Summary, dated 6/20/24, showed NF4 was educated by staff member C on nursing notes and medications/use.</p> <p>Review of a facility provided document, Inservice Education Summary, dated 7/18/24, showed NF4 was educated by staff member C about information on rights of medication and medication errors.</p> <p>Review of a facility provided investigation document with interview information from NF4, dated 10/2/24, showed the following (quoted) responses when the staff member was asked about the specific circumstances involving resident medications:</p> <p>- . Forgot to put it in the Narc book but I gave it .</p> <p>- . under pressure from all different directions .</p> <p>- Yes I was educated on the times and expectations of narcotic documentation .</p> <p>- I just didn't recognize the difference between the two .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- I doubt that you will find documentation because it will 100% be an error on me .</p> <p>- . education and then a PIP, 2nd PIP.</p> <p>Review of a facility provided document titled, Inservice Education Summary, dated 6/20/24, showed NF5 was educated by staff member C on the documentation of nursing notes and medications.</p> <p>Review of a facility provided document titled, Inservice Education Summary, dated 7/18/24, showed NF5 was educated by staff member C about information on rights of medication, and medication errors.</p> <p>Review of a facility document titled, Work Improvement Plan, dated 8/1/24, showed staff member C reviewed with NF5:</p> <p>. all medications to be given per provider order. No scheduled medications will be missed over the next 30 days . Be thorough when taking responsibility of controlled substances. Document all PRN medications at the time of administration. Run PRN report at the end of every shift to ensure proper documentation . weekly medication administration monitoring .</p> <p>Review of a facility provided investigation, dated 10/4/24, showed the following interview response from NF5 when asked about the circumstances involving resident specific medications, I'm not going to lie to you, I don't remember . being careless, not taking my time . The last couple of months I've been busy as shit and I just don't remember.</p> <p>Review of a facility document titled, LN (Licensed Nurse) Core Competency Checklist, showed NF6's competency checklist was signed off by a staff validator on 8/25/23 for meeting competency requirements of medication administration (observation &amp; policy review) and pain assessment, management, &amp; documentation (policy review &amp; documentation demonstration).</p> <p>Review of a facility provided document titled, Inservice Education Summary, dated 6/20/24, showed NF6 was educated by staff member C on nursing notes and medications.</p> <p>Review of a facility email sent 10/10/24 by staff member B, to a corporate sister facility, showed:</p> <p>[NF6] was found to have 3 instances where documentation was not present in the facilities Controlled Substances Book and/or documented in the Medication Administration Record (MAR), in which a medication should have been provided to a resident. Found to have 1 instance where documentation in the facilities Controlled Substance Book indicated a patient received the incorrect dosage of a medication. Through interviews of staff, [NF6] would come in early count the carts and would leave sticky notes for peers to document in Controlled Substances Book were prefilled out dates and mg were filled out by [NF6]. Peers through interviews expressed concerns of being led by NF6 as a senior nurse on the floor. I have finalized the investigation and filed with Nursing Board the findings. We have terminated the other 2 nurses with similar findings and notified the Board of them as well. [sic]</p> <p>Review of facility provided investigation document, with a reporting period of 7/1/24 - 9/30/24, showed NF5 had 21 instances in that timeframe for medications documented in the controlled substance log book that were not also documented in the resident MAR. NF4 had six instances in the timeframe for medications documented in the controlled substance log book but not the MAR.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility provided email from NF7, dated 10/3/24 at 9:05 a.m., showed staff member J performed a review of the narcotic ledger books and resident MARs, with the dates of 9/30/24 and 10/2/24. The review resulted in four residents who were found to have medication documentation concerns in the EHR on 9/30/24, and six residents had medication documentation concerns for 10/2/24. No additional detail was provided in the email.</p> <p>During an interview on 12/18/24 at 8:11 a.m., staff member F stated she saved the top part of resident ordered controlled substance medication cards, when they were empty, to review during the nursing shift change narcotics count. Staff member F stated staff member C had been requiring nursing staff to follow this process since completion of the facility's most recent investigation.</p> <p>During an interview on 12/18/24 at 3:14 p.m., staff member C stated she had stopped conducting routine audits and medication reconciliations, for licensed nursing staff administering controlled substances to residents, for a period of two weeks. Staff member C stated she began to conduct audits and medication reconciliation reviews because of concerns expressed by staff related to NF6 leaving letters to other nursing staff, who were coming on shift, and she wanted them to document controlled substances. Staff member C stated she trained nursing staff on medication administration, and the expectations associated with controlled substance documentation. Staff member C stated she did not have access to view the Cubex (automated medication dispensing machine) use by facility nursing staff, prior to the facility investigation, but obtained access from the pharmacy for regular reviews to be completed after the investigation was completed. Staff member C stated there were no concerns or behaviors displayed by the terminated nursing staff, or reported by other staff, which would have showed a pattern of diversion of narcotics or substance use issues. Staff member C stated, It happened because of sloppy nursing, I gave them all the tools from my toolbox, and it was their choice to use them.</p> <p>During an interview on 12/19/24 at 9:03 a.m., staff member B stated nursing staff were educated if there was one discrepancy found with controlled substances, or any error having to do with narcotics, the staff member would be terminated. Staff member B stated staff member C removed herself from the full facility investigation, so she would be audited and included with all other licensed nurses, for the review and identification of any possible patterns related to the recording and administration of controlled substances.</p> <p>Review of a facility provided document titled, Pulling Controlled Medications from the Cubex (automated medication dispensing) Machine), not dated, showed, . once you have pulled the medication from the Cubex machine you will log it (details of medication taken) into the Controlled Substance Log Book .</p> <p>Review of a facility provided document titled, Controlled Substance Log Book, not dated, showed, . all medications must be visually inspected to be counted. Therefore, sealed controlled medication boxes must be opened for viewing/counting .</p> <p>The result of the investigation showed the above documents were readily available to NF4, NF5, and NF6, all of whom did not follow the instructions in the above documents or follow professional standards of practice related to medication administration of controlled substances.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility policy titled, Medication Administration Section 7.1 General Guidelines, dated 1/24, showed, Medications are administered as prescribed in accordance with . good nursing principles and practices . Medications are administered in accordance with written orders of the prescriber . the individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.</p> <p>Review of a facility policy titled, Medication Administration Section 7.4 Controlled Substances, dated 1/23, showed:</p> <p>The Director of Nursing and the Consultant Pharmacist establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determine the drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled .</p> <ul style="list-style-type: none"> <li>- When a controlled medication is administered, the licensed nurse administering the medication immediately . document dose administration on the MAR .</li> <li>- Any discrepancy in a controlled substance medication count is reported to the director of nursing immediately .</li> <li>- The DON investigates the discrepancy and researches all the records related to medication administration and the supply of the medication, including medication reconciliation.</li> <li>- Medication reconciliation is made from the last known date and time of reconciliation .</li> <li>- The dispensing pharmacy should be notified and the pharmacy should verify that the medication was actually dispensed .</li> <li>- Document the loss and the investigation process. Notify the prescriber and family if doses have been missed .</li> <li>- If diversion is discovered and substantiated, timely notifications must be made to appropriate agencies, such as local law enforcement, Drug Enforcement Administration, State Board of Nursing, State Board of Pharmacy, the state Medicaid Fraud Control Unit, and possibly the State Licensure Board for Nursing Home Administrators.</li> <li>- The director of nursing documents irreconcilable discrepancies in a report to the administrator.</li> <li>- If a major discrepancy or a pattern of discrepancies occurs or if there is apparent criminal activity, the director of nursing notifies the administrator, the consultant pharmacist, and the pharmacy manager.</li> <li>- A determination will be made by the administrator, the pharmacy manager, and the director of nursing concerning other actions to be taken (e.g., notification of police or other enforcement agency). [sic]</li> </ul>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>41652</p> <p>Based on interview and record review, the facility failed to submit the mandatory staffing information for the fourth quarter of federal fiscal year 2024, as required by the Centers for Medicare and Medicaid. Findings include:</p> <p>Review of a CMS report titled, PBJ Staffing Data Report, dated 12/10/24, showed the facility triggered for the failure to submit data for the quarter, and for, One Star Staffing Rating.</p> <p>The facility was notified on 12/16/24, during the entrance conference, the facility triggered for the failure to submit staffing data for the fourth quarter of federal fiscal year 2024 (July, August, and September of 2024). Staff member B stated they would provide copies of the staffing reports, which were submitted by staff member I.</p> <p>During an observation and interview on 12/19/24 at 8:45 a.m., staff member I demonstrated how she submitted the mandatory staffing data required by CMS. Staff member I accessed the Monthly Nursing Home Staffing Report link on the Montana DPHHS website, to submit the facility's staffing data. The link used to submit the data was a Montana state specific website, not the federal website established by CMS, for reporting mandatory staffing data.</p> <p>Review of a facility document titled, Monthly Nursing Facility Report, dated 8/1/24, showed the staffing data which was submitted by staff member I monthly. The facility also provided reports for August and September of 2024.</p> <p>During an interview on 12/19/24 at 8:50 a.m., NF3 stated she received staffing data monthly from nursing homes in the state (Montana). NF3 stated the data was used for activities within Montana only and had no known affiliation to CMS.</p> <p>During an interview on 12/19/24 at 9:00 a.m., staff members A and B stated they contacted a corporate person to clarify who was responsible for submitting the staffing data which CMS required. Staff member A stated her corporate contact explained there had been an error with the July, August, and September 2024 data submission, and they had been unable to get the error corrected so the data could be submitted prior to the deadline. Staff member A stated the facility was not notified when the error occurred or when the data was submitted late.</p> <p>The facility was unable to provide proof of successful submission of the staffing data to CMS for the fourth quarter of federal fiscal year 2024 prior to the end of the survey.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41652</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff practiced proper hand hygiene and appropriate use of personal protective equipment, during care of residents on enhanced barrier precautions, for 1 (#43) of 18 sampled residents.</p> <p>During an observation on 12/18/24 at 9:04 a.m., staff member F was training a new staff nurse, staff member G, on medication pass for residents. Staff member F went into resident #43's room to set up an area to administer scheduled medications by enteral (tube) feeding. Staff member F put on a pair of gloves before entering resident #43's room to administer the medications. Staff member F left resident #43's room to go to a supply room to obtain supplies for the tube feeding with the same pair of gloves on. Staff member F returned to resident #43's room to administer the medications, and did not change the gloves worn out of the room to the supply area, or back. No hand hygiene was performed. Staff member F did not use a gown when the tube feeding was started. The tube feeding was performed without comment from resident #43, or staff member G, who was training with staff member F.</p> <p>During an observation and interview on 12/18/24 at 10:41 a.m., with staff members A and H, there was no EBP signage outside resident #43's room. Staff member H stated she wore gloves when she changed resident #43's wet incontinence brief, after his morning tube feeding, was completed. When asked about any additional PPE which should have been used while providing direct care to resident #43, staff member H stated she was not aware of the additional PPE required for a resident on enhanced barrier precautions. Staff member A stated, We must have forgotten to bring the (PPE) signage when he (resident #43) changed rooms.</p> <p>During an interview on 12/18/24 at 11:10 a.m., staff member C stated, . maybe the roommate took the sign down, when asked about no signage regarding enhance barrier precautions,</p> <p>Review of a facility policy titled, 4.06E Enhanced Barrier Precautions, revised date March 2024, showed:</p> <p>. 1) Enhanced Barrier Precautions (EBP) are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities .</p> <p>2) EBP are indicated for residents with any of the following:</p> <p>. e) Indwelling medical device examples include . feeding tubes .</p> <p>11) Alcohol Based Hand Sanitizer readily available. Hand hygiene is recommended before and after patient contact.</p> <p>12) For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities:</p> <p>. g) Device care or use: . feeding tube .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Laurel Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  820 3rd Ave Laurel, MT 59044	

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 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Review of a facility policy titled, Section 2D Gastrostomy, Jejunostomy Tube: Site Care, not dated, showed, . 2. Wash hands or use hand sanitizer and put on gloves .  51111