STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275112	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Montana Care Center	24 13th St Havre, MT 59501

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 47752 Based on observation, interview, and record review, the facility failed to ensure dignity and respect were honored for privacy of medical information, for 1 (#1) of 6 sampled residents. This deficient practice had the potential to affect all residents who were provided incontinence care by facility staff. Findings include: During an interview on 3/23/24 at 11:27 a.m., NF1 stated she had received a call from NF2 with allegations of abuse and neglect. NF1 stated NF2 was upset because resident #1 had her pubic area shaved while she was provided incontinent care by staff members. During an interview on 3/25/24 at 11:50 a.m., NF2 stated resident #1 had dementia and had very poor short and long-term memory loss. NF2 stated she was made aware of the incident, of the resident being shaved, by staff on 3/8/24 when she had come to the facility to visit resident #1. NF2 stated she had asked nursing staff about bruising that was noted to resident #1's arm. NF2 stated she was told the bruising was from a lab draw that morning. NF2 stated, That is when I found out that resident #1 had her pubic region shaved by two CNAs. NF2 stated she went back to resident #1's room and checked the resident's pubic region. NF2 stated she had not noticed any bruising on resident #1's legs or thighs, but I did not check her as close as I wish I would have. NF2 stated, I am very upset with her care. The facility is acting like what happened to resident #1 is ok. I know resident #1, and she would not have allowed this to happen. NF2 stated she called NF1 and staff member C and let them know I had called NF1. NF2 stated, I am very angry about this. Why would anyone do this to an elderly person? NF2 stated she had also called and spoke with NF3, a nurse at the clinic on 3/12/24. NF2 stated, I had asked her if resident #1 needed a rape exam. NF2 stated after she had talked to NF3 she had also talked to staff member L. NF2 stated, Staff member L told her a gynecological exam would be very hard on resident #1, and the exam would have to be done under anesthesia. NF2 stated she told staff member L she did not want the exam done at that time. NF2 stated the facility has a video of the time this happened, and they will not allow me to view it. NF2 stated she had attended a care conference in January of 2024 regarding resident #1. NF2 stated, During the care conference I had told staff member C I preferred to have female caregivers for resident #1, but there were a few male CNAs that were ok to provide care to resident #1. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility video on 3/25/24 at 11:42 a.m., showed staff member E walked into resident #1's room and walked back out. Staff member E started to walk down the hallway, and appeared to be looking for resident #1. At 11:47 a.m., resident #1 was walked back to her room by staff members E and H. At 11:56 a. m., staff member E walked out of resident #1's room and returned at 11:56 a.m., with shaving cream and a razor. At 12:09 p.m., staff member M opened the door slightly and looked inside the room. At 12:11 p.m., staff member D opened the door to resident #1's room and went inside. At 12:13 p.m., staff member D exited resident #1's room with resident #1 and walked down the hallway. During an observation and interview on 3/25/24 at 12:40 p.m., resident #1 could not answer questions appropriately and walked back out of her room. Staff member F walked resident #1 back to her room and attempted to assist her with lunch. During an interview on 3/25/24 at 1:30 p.m., staff member B stated the expectation for staff was to talk with the charge nurse on shift if there was anything that happened out of the ordinary, or if a resident needed a different level or type, of care. Staff member B stated, I don't know what was going through their heads (staff who shaved the resident), but I definitely do not feel it was malicious at all. During an interview on 3/25/24 at 1:57 p.m., staff member C stated staff members E and H were not suspended after the incident. Staff member C stated, I am not sure why we did not suspend them other than we (administration) felt this was a care issue and not a reportable incident. I spoke with both staff members, and they explained what had happened. I know that when staff member A received a call from NF3 with the concerns NF2 verbalized, we started an investigation immediately. We called and spoke to the police department as well. During an interview on 3/25/24 at 2:28 p.m., staff member D stated she was the charge nurse on 3/5/24. Staff member D stated, I did not know what had happened until afterwards. I was breathless. I tried to call staff members A, B, and C for guidance but never got any response from them. I should have called family, but I didn't. During an interview on 3/25/24 at 2:45 p.m., staff member E stated staff member D told them (the CNAs) it was time to check and change resident #1. Staff member E stated, Resident #1 was not in her room, but we had found her and took her to her room to be changed. Staff member H was working on a different unit, but offered to help me because the other CNAs were still looking for resident #1 and had not come back to the unit yet and resident #1 smelled bad and needed to be cleaned up. We laid resident down on her bed and found that she was wet and had very thick BM all over. Staff member H took some wet washcloths and started to clean her up. Resident #1 was calm at this time. Resident #1 became upset when we tried to clean her peri-area. Resident #1 had said 'ouch'. Staff member H stopped cleaning resident #1 at that time so he did not hurt her, he asked me to go and get some shaving cream. We put the shaving cream on resident #1's peri-area and let it sit there, hoping it would loosen up the BM. The shaving cream did not help so staff member H started to shave the BM out of her (the resident's) pubic hair. I told staff member H we should check with the nurse, but he did not stop shaving her, and I did not leave to go get the nurse. When we were almost done the nurse came into the room to see what was taking so long and that is when I told her what was done. She looked at resident #1's peri-area, then walked with resident #1 out of the room. A call was placed to staff member H on 3/25/24 at 2:59 p.m., A message was left with the State Surveyor's call back information. The staff member returned the call at 6:04 p.m. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/24 at 6:04 p.m., Staff member H stated, Me and staff member E ended up shaving resident #1. Resident #1 wanders a lot, and we were trying to locate her. When we found her, she smelled bad. We took her back to her room to clean her up. She was wet and covered in thick BM. I tried to clean her using wet washcloths but that did not work. We shaved the BM out of her pubic hair. The resident was calm while we were cleaning her up. I let the nurse know after we shaved her. I did not think this would be such a big deal. We were just trying to clean her up with out hurting her. I really thought we were doing the right thing. During an interview on 3/26/24 at 7:15 a.m., staff member A stated he reported the incident to the State Survey Agency as soon as he had gotten off the phone with NF3 and was made aware of the allegations NF2 made. Staff member A stated, Staff member C and I started an investigation right away and reported the incident to the police department, started interviewing residents, and interviewed staff. Staff member A stated, I am not sure what they were thinking, they absolutely did it backwards. They truly believe that what they did was helping the resident. I do not believe what they did was malicious or showed any willful harm to the resident. Every staff member has been educated on dignity, incident reporting, and abuse and neglect, since this incident occurred. Resident #1 is now to be cared for by female staff only. During an observation on 3/26/24 at 9:20 a.m., resident #1 was toileted by staff members G and J. Peri-care was performed. Resident #1's peri-area was not red. The pubic area was shaved in the upper part of the pubis region and showed hair growth. Resident #1's pants were pulled into place and resident #1 began to scratch at her peri-area and stated it itched. During an interview on 3/26/24 at 9:45 a.m., staff member I stated he used to provide care for resident #1. Staff member I stated, Resident #1 does not understand what cares are being done. Sometimes she would let me provide care for her and other times she would not. I was told by NF2 that it was ok to still care for resident #1 because she liked me. I do not provide any care to resident #1 since she is now female only caregivers. During an interview on 3/26/24 at 9:57 a.m., NF4 stated she was also looking into the incident involving resident #1. NF4 stated she had spoken to NF2 and spent some time with resident #1. NF4 stated resident #1 would not engage with her and her investigation is not complete at this time. During an interview on 3/26/24 at 12:35 p.m., Staff member L stated, I had been made aware of the situation involving resident #1 and had cared for resident #1 for many years. I had spoken to NF2 after she had called and spoke to NF3 about the incident. NF2 asked about the need for a rape kit. I explained in great detail that it was not a good idea because it would be very traumatic for resident #1. I explained the exam would have to take place under anesthesia and with team of OB/GYN doctors. I did not refuse to examine her, I just explained how traumatic physically and emotionally it would be for her. I honestly thought the family was ok with the solutions that were implemented. It surprises me it has gone this far. Resident #1 has been stable and there had not been a change in her baseline behavior. The family fixates on certain things or medical tests or demand an unrealistic expectation of care. I do not think this was meant to harm resident #1. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 2:32 p.m., NF3 stated she had received a phone call from NF2 on 3/12/24. NF3 stated NF2 expressed that she did not know who to talk to about the incident that had occurred. NF3 stated, I explained to NF2 that I was not part of administration for long term care, but I let her finish ranting. NF2 kept asking questions about the incident that I could not answer. I had encouraged NF2 to call and speak with staff members A, B, and C, about her ongoing concerns. After I had got off of the phone with NF2, I called and spoke to staff member A about the concerns. A review of staff member E's new hire paperwork, dated 8/31/22, and Staff member H's new hire paperwork, dated 5/10/23, showed: Staff members E and H been educated and passed Relias training regarding abuse/neglect, resident care, and resident rights. Staff members E and H signed an acknowledgement of resident's rights. A review of a facility document titled, Quality of Care Expectations, with a reviewed date of 1/2024, showed: . C. Dignity and Respect. 1. The resident's private space and property shall be respected at all times. . I. Psychosocial 6. Staff shall recognize psychosocial needs including the following: a. Dignity.