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	06/30/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to ensure there was a physician order and consent signed on in the EHR for a physical restraint, which was a seatbelt used for a resident who used a motorized wheelchair to assist with preventing falls, for 1 (#50) of 30 sampled residents. Findings include: During an observation on 6/28/25 at 5:26 p.m., resident #50 had a seatbelt on while he was sitting in his motorized wheelchair. Review of resident #50's EHR showed no consent or physician order was present for the seatbelt, which restrained the resident, in his motorized wheelchair. Review of resident #50's EHR showed a physician's note, dated 9/6/24, which showed the following diagnoses: bipolar I disorder, intellectual disability, developmental delay, PTSD, hypertension, insomnia, prediabetes, traumatic brain injury, history of institutionalization, aggressive behavior, difficulty with speech, on a combination of antipsychotic drug therapy, and a history of a sacral pressure ulcer. During an interview on 6/30/25 at 8:52 a.m., staff member E stated they were unaware a physician's order and a consent was needed for a seatbelt, which was used to help prevent the resident from falling, but they would fix the concern quickly. A review of #50's Quarterly Minimum Data Set Assessment, with an Assessment Reference Date of 5/21/25, showed the resident was not able to complete the Brief Interview for Mental Status. He was coded as having inattention and disorganized thinking. He had both upper and lower extremity deficits, and was dependent for mobility. The resident was not coded as using a restraint. During an interview on 6/30/25 at 9:05 a.m., staff members A and C stated they had not considered a seatbelt on a motorized wheelchair to be a restraint. Staff member A stated they now realized how it could be used as a restraint, especially with a resident with a lower cognitive ability. Staff member A and C stated it was a requirement that physical therapy do an assessment with the resident, which was not completed for the seatbelt resident #50 had on the chair. Review of a facility policy titled, Restraint Policy, last revised, 4/2020, showed: - It is the policy of the [Entity Name] to prohibit the use of restraints, safety devices and postural supports, except when used to treat a resident's medical symptoms. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Restraint: Any method (chemical or physical) of restricting a person's freedom of movement that prevents independent and purposeful movement. This includes . controlling physical actvity . - Safety device: . the definition of a safety device to be an applicance used to maximize the independence and the maintenance of health and safety of an individual by reducing the risk of falls and injuries associated with the resident's medical symptoms. - No restraint of any kind may be employed unless the order for one has been signed by the LTC Administrator, LTC Director of Nursing, and LTC Director of Social Services.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure a PASARR was completed for 1 (#64) of 30 sampled residents. This deficient practice increased the risk of the resident not being assessed or receiving necessary services related to the resident's mental health diagnosis or PTSD. Findings include: During an interview on 6/28/25 at 3:38 p.m., resident #64 stated he had PTSD from the war. Review of resident #64's EHR showed a diagnosis of PTSD. A request was made on 6/29/25 at 11:57 a.m., for resident #64's Level I and Level II PASARR. During an interview on 6/29/25 at 2:03 p.m., staff member C stated the facility did not have a PASARR for resident #64. Staff member C and staff member A stated they worked with [Entity Name] who filed most of their paperwork, and resident #64's PASARR must have gotten lost in the transfer to [Entity Name].

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update individualized resident care plans regarding behaviors and previous trauma, for 2 (#s 61 and 64) of 30 sampled residents. This deficient practice increased the risk for #61 and #64 not having preferences met or known, and a resident's exhibited behaviors continuing without interventions being implemented. Findings include: During an interview on 6/29/25 at 3:49 p.m., staff member F stated resident #61 and resident #64 would have some outbursts or display behaviors at times. Staff member F stated the facility had behavior charting when those events occurred. a. Review of resident #61's EHR showed a nursing note, dated 6/28/25, which showed, Resident was in dining room for breakfast when another resident yelled out then she (resident #61) proceeded to yell at that resident to Shut up and cursing at that resident. then resident was cursing at staff and came out and told this nurse im gonna knock [name] on her ass one day. and continued fussing and curing (cursing) while going to her room. [sic] Review of Resident #61's individualized care plan, last reviewed 4/17/25, showed no mention of a problem, goal, or interventions regarding resident #61's outbursts and verbal behaviors towards other residents or staff. b. Review of resident #64's EHR showed PTSD as a diagnosis. Review of resident #64's individualized care plan, last revised 6/5/25, showed there was no problem, goal, or nonpharmacological interventions identified and documented to be utilized by staff regarding resident #64's PTSD. During an interview on 6/30/25 at 9:05 a.m., staff member A and C stated the staff were doing interventions daily regarding resident #61's behaviors and resident #64's PTSD, but stated the facility could be better about taking credit for those interventions and documenting them.

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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. Based on observation, interview, and record review, the facility failed to ensure 1 (#57) of 30 sampled residents were safe from wandering the facility and into 4 other residents' rooms (#s 7, 31, 41, and 64). This deficient practice increased the risk of negative interactions between the residents related to safety and infection control concerns. Findings include: During an interview on 6/28/25 at 3:38 p.m., resident #64 stated resident #57 was often confused and would wander into his room, sometimes at night. Resident #64 stated he did have a history of PTSD, and resident #57 walking into his room made him feel uncomfortable. Resident #64 stated resident #57 would sometimes steal things from his room. Resident #64 stated he was told by staff to put his items away when he left his room to prevent resident #57 from taking any of his items. During an observation on 6/29/25 at 3:21 p.m., resident #57 was in her wheelchair, and she wheeled into resident #7's room when the resident was sleeping. Resident #57 watched resident #7 for approximately 30 seconds, then exited the room. During an observation on 6/29/25 at 3:24 p.m., resident #57 wheeled her wheelchair into resident #41's room. Resident #57 touched resident #41's chair and the leg rests located on the wheelchair. During an observation on 6/29/25 at 3:25 p.m., resident #57 wheeled her wheelchair into resident #31's room and touched resident #31's shoes. During an interview on 6/29/25 at 3:45 p.m., staff member F stated resident #57 was able to move throughout the entire facility, and the staff relied on the wanderguard to ensure her safety. Staff member F stated it was not a concern that resident #57 was in other resident's rooms, other than resident #64, as he expressed this bothered him. Staff member F stated resident #57 had gone through another resident's closet before as well as wandering into other resident rooms. Staff member F stated there could be a concern for infection control with resident #57 wandering into so many resident's rooms. Review of a facility policy titled, Wandering Behavior with Usage of the RoamAlert System, revised 3/19, showed: . 3. Determine when wandering requires interventions to reduce unwanted intrusions on other residents. [sic]