STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275121	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sidney Health Center Extended Care	104 14th Ave NW Sidney, MT 59270

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 14005 Based on interview and record review, the facility failed to adequately respond to allegations of abuse (bruises of unknown origin) and have evidence the alleged violation unknown bruising was investigated thoroughly; and the facility failed to show the allegation was reported to the required officials, for 1 (#94) of 14 sampled residents. Findings include: Review of resident #94's nurse progress note, dated 8/28/24 showed the last reported fall was 8/28/24 at 2:20 p.m., where she was noted sitting on the floor in front of her recliner. No redness or discoloration was noted after the fall. Review of resident #94's nurse progress note, dated 9/5/24 at 4:29 a.m., showed resident #94 had bruises of unknown origin on her buttocks. Staff member NF3 assessed the residents' buttock and noted dark purple and red bruising to her right upper buttocks, on her mid buttocks, and right lower buttocks to mid upper post thigh. The resident's progress note showed facility management had been notified at 5:26 a.m. Review of #94's nurse progress note, dated 9/5/24 at 5:26 p.m., showed the bruises of unknown origin were measured and described as, Dark red/purple bruising to resident's post upper/inner thigh area measures 17. 5 x 11.5 cm; scattered small purple bruises present to resident's right hip; right outer hip area 9x4 cm; and upper inner buttock dark red/purple bruise measures 13 x 7 cm. This was reported to management and will be reported to day nurse. Resident does have complaints of pain in these areas. Review of the facility event report resident #94 recorded on 9/5/24 at 1:35 p.m., showed the event occurred on 9/4/24 at 8:33 p.m. The report shows the bruises to right buttock were likely from sitting down hard on the toilet. Review of resident #94's nurse progress note recorded as a late entry for 9/7/24 at 3:24 a.m., showed NF5 and the resident's family wanted to know the cause of the bruising. The nurse told NF5 she would have to talk to the director of nursing. Staff member NF3 texted the director of nursing this information. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/7/24 at 2:38 p.m., staff member NF3 said resident #94 had dementia, was weak and needed staff assistance to toilet, and at times even needing a complete lift transfer. Staff member NF3 said she was not aware of any time when the resident sat down hard on the toilet. Staff member NF3, who initially identified the bruises, said the bruised area was higher on the buttocks than then where the toilet seat would normally be in relation to the resident's buttocks. NF3 said staff member G said resident #94 was recently found on the floor and had put her back to bed. Staff member NF3 said staff member G worked the night shift, and NF3 said she worked quite a few shifts (scheduled eleven shifts in a row and then three days off) and was not aware of a fall occurring on her shift. During an interview on 10/8/24 at 11:55 a.m., an anonymous staff member said in the past resident #94 sits down hard onto the toilet, however, she had not sat down hard at any time recently when she had been assisting her. This staff member also said during the time this was being investigated, one of the other staff admitted to knowing the resident had fallen on the floor. This staff member would not identify the staff involved with the resident fall. During an interview on 10/9/24 at 5:30 p.m., staff member G said she was not sure what date the incident was, but it was probably about the beginning of September. Staff member G said she found resident #94 on the floor in her room laying on her back. Staff member G said she got the nurse to help get resident #94 back in bed. Staff member G said she was not asked to get any vitals or do any checks on resident #94 which is not the usual practice. Review of the abuse investigation showed the State Survey Agency had not been notified about the bruises of unknown origin on resident #94's buttocks and thighs. The investigation showed there were only four people interviewed in attempt to identify the cause of the bruising. The interviews for the four staff members were not dated to identify when the investigation was initiated. One note written by staff member G identified a fall, however this was not further investigated.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on interview and record review, the facility failed to develop and implement a baseline care plan for oxygem use within 48 hours of admission, and the resident had a hypoxic event, for 1 (#1) of 3 recently admitted sampled residents. Findings include: Record review of resident #1's baseline care plan showed resident #1 was admitted on [DATE], and the baseline care plan did not include problems, goals, or interventions for oxygen use. During an observation and interview on 10/10/24 at 8:15 a.m., staff member D reviewed the comprehensive care plan which would include the baseline care plan. Staff member D said the oxygen usage was not on the baseline care plan, but there was nothing she could do about it now. Staff member D identified the oxygen was added to the care plan after the hypoxic event on 8/19/24. A review of resident #1's August 2024 Physicians Order Report showed the resident had an order on 8/8/24 (admitted) for oxygen at 2-4 liters per minute, per nasal cannula, to keep SaO2 at 90% or above. On 8/14/24, the physician's orders were .Titrate O2 as needed; Goal is to keep 88% or above. Currently at 4 liters continuous. During an interview on 10/8/24 at 2:56 p.m., NF2 said resident #1 had been using oxygen on a continuous basis for many years prior to coming to the nursing home.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 14005 Based on interview and record review, the facility failed to provide a resident with necessary respiratory care and services in accordance with professional standards of practice and the resident's physicians orders, which caused the residents to have insufficient oxygen saturations for 2 (#1 and #10) of 14 sampled residents. Findings include: a. During an interview on 10/8/24 at 11:35 a.m., staff member M said resident #1 had been in the tub room without her oxygen on when the resident turned blue and was not responding. Staff member M applied oxygen to resident #1, assessed the resident, and called the physician for orders. Staff member M was unable to remember the exact date this incident occurred. Staff member M said the CNA scheduled to care for resident #1 was new. Staff member M said she did was unaware if the CNA had been educated to know which residents were on oxygen. During an interview on 10/8/24 at 2:56 p.m., NF2 said someone from the facility called him and said, We made a mistake and took resident #1 to the dining room for breakfast without her oxygen. NF2 could not remember the name of the person who called him, but the staff member said resident #1's oxygen level was low, the resident had some seizure like activity, and the oxygen had to be increased to 15 liters to get her oxygen level up. NF2 said resident #1 had been using oxygen on a continuous basis for many years. NF2 said he placed a sign in the room after the incident to remind staff to always use oxygen. Review completed on 10/9/24 of the August nursing staffing schedule, staff member H and M were scheduled and assigned to work with resident #1. The schedule was verified with staff member F. During an interview on 10/9/24 at 1:46 p.m., staff member I said she did work the day shift on 8/19/24. Staff member I said resident #1 did go to the dining room for breakfast on 8/19/24. Staff member I is unaware of any incident concerning resident #1. Staff member I said residents use concentrators in their rooms and when out of their rooms, the residents use tanks on their wheelchairs. During an interview on 10/9/24 at 2:01 p.m., staff member H said she was working day shift on 8/19/24. Staff member H said she did not take care of resident #1 that day, but she said she knew resident #1 had an episode in the tub room when she did not have her oxygen on. A review of resident #1's August 2024 Physicians Order Report showed the resident had an order on 8/8/24 for oxygen at 2-4 liters per minute per nasal cannula to keep SaO2 at 90% or above. On 8/14/24, the physician's orders were .Titrate O2 as needed; Goal is to keep 88% or above. Currently at 4 liters continuous. A review of resident #1's nursing progress notes dated 8/19/21 at 3:30 p.m., showed resident #1 had a hypoxic episode in the tub room. Resident #1 did not have her oxygen on, and the nurse ran to grab some oxygen. The nurse applied the oxygen at 4 liters per minute and did a sternal rub to help rouse resident #1. An assessment was completed by the nurse, and the physician was notified. The CNA was educated on the importance of resident #1 having oxygen on continuously. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	A review of the physician progress notes, dated 8/19/24, showed resident #1 had severe COPD and is oxygen dependent at 4 liters per minute. The physician note showed he was called to the common area in the nursing home where resident #1 is found to be unresponsive for probably seconds likely secondary to severe hypoxia with the minor movements making her hypoxic. The physician directed the staff to send the reident tot he emergency room if her condition worsened. Review of resident #1's care plan, did not include oxygen use until the plan was revised on 8/19/24. On 8/19/24, oxygen at 4 liters per minute was added to the care plan. The care plan showed the rate could be adjusted to assist with recovery, but there were no parameters for oxygen use. The care plan was revised again on 8/20/24, showing a sign was placed above the oxygen tank to remind staff for continuous oxygen use and oxygen use was added to the CNA report sheet. b. Review of resident #10's physician orders showed an order for oxygen at 2-liters per minute per nasal cannula to be administered continuously due to hypoxia. During an interview on 10/8/24 at 11:47 a.m., staff member N said she was making rounds on the dementia unit. Staff member N found resident #10 did not have her oxygen on. She said resident #10's oxygen level was low, so she immediately applied oxygen. A review of resident #10's progress notes, written on 10/8/24, and documented as a late entry for 9/30/24, showed, resident #10 did not have oxygen on, and her oxygen saturation was 88%. The note showed the nurse educated the CNA on continuous O2 orders. Staff member N documented the oxygen level came up to baseline after oxygen was applied. A review of the facility's policy, titled Oxygen Administration, showed the following: Purpose: To treat and to prevent symptoms of hypoxia, such a tachypnea, tachycardia, shortness of breath and cyanosis (PaO2 below 60mmHg and/or saturation by pulse oximetry below 90%). Oxygen is a drug and, as such, a physician must order its use.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 14005 Based on observations and interview, the facility failed to ensure a Director of Nursing (DON) was working full-time for 35 or more hours per week, in the facility. This failure increased the risk of negative outcomes for all residents in the facility related to nursing care and services, due to the lack of onsite oversight provided by the DON to ensure completion of all necessary resident cares and treatments in the facility. During this survey, harm was identified related to respiratiry care and services, which was identified to be a system concern, and affected 2 (#1 and #10) of those who were sampled for respiratory care. Findings include: During an interview on 10/8/24 at 4:15 p.m., staff member A stated the facility had been advertising for a permanent director of nursing but had been unable to hire anyone. Staff member A said the facility had hired a director of nursing through and interim agency, and part of the contract included her ability to work on site for two weeks, and then work remotely offsite for two weeks. It was identified the facility failed to provide residents with necessary respiratory care and services in accordance with professional standards of practice and the resident's physicians orders, which caused the residents to have insufficient oxygen saturations for 2 (#1 and #10). Refer to F695, Respiratory Care and Services for more information related to the harm identified. Observations made during the survey showed the director of nursing was not present in the facility during the following time frames: - 10/7/24 at 12:15 p.m., until 5:15 p.m. - 10/8/24 from 7:15 a.m. until 5:40 p.m. - 10/9/24 from 7:15 a.m. until 5:40 p.m. - 10/10/24 from 7:15 a.m. until 9:15 a.m.