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	08/29/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on interview and record review, the facility failed to ensure Provider Orders for Life-Sustaining Treatment (POLST) forms were completed for 3 (#s 2, 7, and 36) of 24 sampled residents. Findings include: 1. Review of resident #2's hard-copy and electronic copy POLST forms, showed: - In the mandatory signature and date section: the form was not dated when signed by the resident's legal decision maker. 2. Review of resident #7's hard-copy and electronic copy POLST forms, showed: - In the mandatory signature and date section, the form did not include the printed name, telephone number, or dates the form was prepared and signed. 3. Review of resident #36's hard-copy and electronic copy POLST forms, showed: - In the mandatory signature and date section: the form did not have the printed name, telephone number, and dates showing when the form was prepared and completed by the medical provider. During an interview on 8/28/24 at 8:27 a.m., staff member A stated staff member K oversaw resident POLST forms and the advance directives. Staff member A stated when a resident transferred to the facility from the hospital, POLST forms were usually started in the hospital. During an interview on 8/28/24 at 11:36 a.m., staff member K stated she didn't check on POLST forms when another staff member started filling one out, and she didn't check to see if the sections of those forms were filled out. Staff member K stated POLST forms were discussed at individual resident care plan meetings. Staff member K stated her usual practice with POLST forms is to have them filled out on admission for residents when she meets with them. Staff member K stated, There is no process for someone starting it and making sure the POLST form is completed. Review of a facility policy titled, Advance Directives and Physical Information, with a revision date of February 2020, showed: (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. [Facility Name], Extended Care will provide written information to residents, concerning his or her rights under State law to make decisions concerning medical care, including the right to accept or refuse medical treatment or surgical treatment and the right to formulate advance directives. 8. Facility staff will inform each resident of the name, specialty and way of contacting the physician responsible for their care. A request was made to the facility on [DATE] for a POLST policy. No additional documentation was received by the end of the survey.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 51111 Based on interview and record review, the facility failed to fully investigate and resolve a reported concern and grievance for 1 (#34) of 24 sampled residents. Findings include: During an interview on 8/26/24 at 2:46 p.m., resident #34 discussed a grievance she voiced to the facility staff, and stated she told staff member B a nurse smelled of perfume, which had a strong gagging odor. Resident #34 stated she was concerned if the smell was affecting her so strongly, she wondered how other residents with respiratory issues were handling it. Resident #34 stated this concern was voiced at a care planning meeting, where staff members F and K were present. Resident #34 stated she did not have follow-up from the grievance voiced during her care planning meeting. During an interview on 8/28/24 at 11:36 a.m., staff member K stated she was aware of a concern from resident #34 regarding her grievance on the strong perfume odor on a nursing staff member. Staff member K stated staff member B was going to follow-up on the concern with the identified nursing staff. During an interview on 8/28/24 at 4:27 p.m., staff member J stated employees were instructed at the beginning of their employment, scents were not to be used except lightly scented deodorant and laundry soap smells on clothes were allowed. Staff member J stated within the past month, she had reported to a nurse supervisor a strong smelling odor of perfume on the same staff member who was named by resident #34 in her concern. During an interview on 8/29/24 at 8:07 a.m., staff member A stated there was no written documentation found for resident #34's grievance or concerns with the the staff member's strong perfume odor. Staff member A stated staff member B addressed the concern with staff verbally. Staff member A stated she was unsure if follow-up had occurred. Review of a facility policy titled, Right to Voice Grievances, with a revision date of January 2016, showed: . 2. Verbally reported concerns/complaints can be given to any nurse, Social Services Director, Director of Nurses, Administrator . 5. The facility will investigate the concern and respond to the grievance in a prompt manner. See Attached Form used by staff to document the investigation. A facility representative will contact the person who made the grievance with the results of the investigation. The facility will state what action(s) to be taken to prevent further occurrences . 8. The facility will maintain documentation regarding the complaint for a minimum of three years .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51111 Based on observation, interview, and record review, the facility failed to ensure a comprehensive person-centered care plan was created for 1 (#31) of 24 sampled residents who utilized oxygen. From admission, the resident had three MDS assessments completed, all showing oxygen therapy was provided, but the care plan was never updated, showing a repeated pattern for the failure. Findings include: Review of resident #31's electronic medical record showed on admission, the resident's pertinent diagnoses included: acute and chronic respiratory failure with hypoxia, pneumonia, and pulmonary hypertension. A review of resident #31's MDS assessments, to include the Admission assessment, dated 2/26/24, and two Quarterly assessments, dated 5/15/24 and 8/7/24, showed oxygen therapy was marked in section O0II0 for respiratory services. During an observation on 8/26/24 at 3:42 p.m., resident #31 was observed wearing a nasal cannula, connected to an oxygen concentrator, with the oxygen flow rate set at 3 liters. An oxygen tank was observed in a pack, strapped to the back of resident #31's wheelchair, and a second oxygen tank was observed on the side of the room, next to resident #31's bed. During an interview on 8/26/24 at 3:44 p.m., resident #31 stated she has lived in the facility for about six months. Resident #31 stated her reason for admission was due to difficulties with breathing. Resident #31 stated she had been using oxygen since admission and it helped with her breathing. During an observation on 8/28/24 at 11:24 a.m., resident #31 was observed wearing a nasal cannula, which was connected to an oxygen concentrator, and the oxygen flow rate was set at 3 liters. Review of resident #31's comprehensive care plan, revised on 8/20/24, failed to include a problem, goals, or interventions related to the resident's oxygen use and respiratory status, resident assessment for oxygen use/needs, oxygen saturation level to be maintained, oxygen flow rate, precautions, directions for staff, or equipment care/management for oxygen. The failure to add and address the oxygen use on the care plan was a repeated failure from the resident's admission to the date of the survey. Review of a facility policy, titled, Comprehensive Care Plans, with a revision date of January 2013, showed: . The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment . 1. Comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The care plan will be prepared by and interdisciplinary team, that includes the attending physician, a registered nurse with the responsibility for the resident and other appropriate staff in disciplines as determined by the resident's needs . 3. The care plan will be periodically reviewed and revised by a team or qualified persons after each assessment .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 14005 Based on interview and record review, the facility failed to review and revise the individualized resident care plans with interventions, for 2 (#s 4 and 10) of 24 sampled residents, showong. Findings include: 1. Review of resident #10's nursing progress note, dated 11/30/23, showed resident #10 was found on the floor, in the doorway, of her bathroom. Resident #10 complained of head pain which resulted from the fall. Review of resident #10's event report dated 11/30/23, showed possible contributing factors that could have increased resident #10's risk for falling. The facility failed to identify the root cause of the fall. Due to the failure to determine the cause of the fall, the care plan was not updated to reduce the risk of night time falls or toileting needs. Review of resident #10's fall prevention care plan showed no revisions or updates for fall interventions on 11/30/23. The fall care plan was not updated until 7/8/24. During an interview on 8/29/24 at 10:17 a.m., staff member F said she did not review or make changes to the care plan after the resident fall. Staff member F said the nurses taking care of the residents are to identify the root cause of the fall and update the plan of care. Staff member F said if the nurse makes a change to the care plan, it isn't reviewed, and stated, If it's in there, it is in there. Staff member F said, This is a work in progress, and with the lack of stability, there is no one checking anything. 51111 2. During an observation on 8/27/24 at 10:40 a.m., resident #4 was sitting in an electric wheelchair, and two gait belts were holding her legs together. One gait belt was strapped around her knees, and one gait belt was strapped around both her ankles. During an interview on 8/26/24 at 2:13 p.m., resident #4 stated she requested to use gait belts to hold her legs together while sitting in her wheelchair. Resident #4 stated her multiple sclerosis caused muscle weakness, and she couldn't hold her legs together comfortably, while in the wheelchair. Resident #4 stated her legs would splay outwards off the wheelchair's footrests. During an interview on 8/28/24 at 8:00 a.m., staff member I stated, in the mornings, CNAs would apply lotion to resident #4's legs and put two gait belts on resident #4's legs, per resident #4's request. Staff member I stated she did not document any application of gait belt use, and stated, I don't think the gait belts are in her [resident #4's] care plan or mentioned anywhere. Review of resident #4's comprehensive care plan, with a revision date of 7/24/24, showed: Problem Start Date: 5/17/17 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Category: Pressure Ulcer/Injury - Risk for impaired skin integrity d/t muscle weakness as evidenced by inability to control her lower extremities . 'Able to buckle and unbuckle seat belt that she uses while in her W/C . In W/C the majority of the day'. The care plan problem did not address the use of the two gait belts on her legs. Review of resident #4's comprehensive care plan did not include problems, goals, or interventions to address: - The resident's request for the gait belt usage to restrain both legs due to her disease process. - Did not show the restraint assessment was completed, and or that the belts were not used as a restraint or for convenience of staff. - Risks associated with the gait belt usage. - Necessary skin assessments due to the daily use of the gait belts and pressure on the resident's legs. - Directions for how staff were to place, remove, and check the gait belts. - Cleaning of the belts. - When gait belts were to be used, such as time of day, and if it was to be only when she was in her wheelchair. - If/when the usage of the gait belts would be re-evaluated. Review of a facility policy titled, Comprehensive Care Plans, with a revision date of January 2013, showed: . The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetable to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. . 3. The care plan will be periodically reviewed and revised by a team or qualified persons after each assessment .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 14005 Based on interview and record review, the facility failed to ensure the monthly drug regimen review process was used to identify and report irregularities to the attending physician, for 1 (#33) of 24 sampled residents. Findings include: Review of resident #33's physician progress note, dated 3/16/24, showed, It is not clear if she has been using her Xanax on a regular basis or only as needed. A request was made on 8/27/24 and 8/28/24 for medical provider documentation addressing the continued as needed/PRN use of Xanax. No additional information or documentation was received by the end of the survey. Review of resident #33's pharmacy progress notes, dated 5/14/24 and 7/10/24, showed psychotropic medication monitoring was completed. The document showed the as needed Xanax started in March 2024. The pharmacist's documentation showed the as needed use of Xanax beyond the 14 days was acceptable based on the pharmacist review. The pharmacist documented, Xanax is not an antipsychotic, therfore, duration beyond 14 days is acceptable [sic]. The pharmacist documented the as needed Xanax will continue. The pharmacist failed to identify a problem with the continued use of an as needed psychotropic medication beyond the 14 day recommended discontinuation. Review of the facility policy, titled Psychotropic Medication Management, dated 6/1/24, showed, . PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days) . if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their clinical rationale in the resident's medical record and indicate the duration for the PRN order . During an interview on 8/28/24 at 8:21 a.m., staff member D said he is responsible for tracking the psychotropic drug use, recommending gradual dose reductions, and notifying the facility and physicians of medication irregularities. Staff member D said resident #33 was okay to have as needed Xanax because the doctor was going to make it scheduled. Staff member D said the physician had ordered as needed Xanax to be refilled five times.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 14005 Based on interview and record review, the facility failed to ensure an as needed psychotropic medication was reviewed or discontinued after 14 days for 1 (#33) of 24 sampled residents. Findings include: Review of resident #33's physician progress note dated 3/16/24, showed, It is not clear if she has been using her Xanax on a regular basis or only as needed. A request was made on 8/27/24 and 8/28/24 for medical provider documentation addressing the continued as needed use of Xanax. No additional information was received by the end of the survey. Review of pharmacy progress notes dated 5/14/24 and 7/10/24, showed psychotropic medication monitoring was completed. The document showed the as needed Xanax started in March 2024. Review of the facility policy titled Psychotropic Medication Management dated 6/1/24, showed, . PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days) . if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their clinical rationale in the resident's medical record and indicate the duration for the PRN order . During an interview on 8/28/24 at 8:21 a.m., staff member D said he is responsible for tracking the psychotropic drug use and recommending gradual dose reductions. Staff member D stated the physician documented his notes in a different computer system than what the extended care center uses. No additional information was received by the end of the survey for physician justification for the continued use of as needed Xanax.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 51111 Based on observation, interview, and record review, the facility failed to ensure consistent enhanced barrier precautions were provided for 2 (#s 16 and 37) of 24 sampled residents; and the facility failed to provide documentation of infection surveillance and mandatory communicable disease reporting for six consecutive months which had an increased risk to the entire facility population. Findings include: 1. During an observation on 8/26/24 at 2:39 p.m., resident #37's door had a yellow isolation bag filled with gowns, gloves, and wipes hanging from the front of the door. There was no precaution sign on the door. During an observation and interview on 8/27/24 at 8:51 a.m., staff member M stated he did not know why resident #16 had an enhanced barrier precaution sign on his door. Staff member M said any enhanced barrier precaution supplies would be kept in resident #16's bathroom. Staff member M stated he knew where to find precautions for the residents. During an observation of resident #16's door, a sign for enhanced barrier precautions was displayed, and when observed, resident #16's bathroom and room had no equipment or PPE supplies. During an observation on 8/28/24 at 7:58 a.m., on resident #37's door, a yellow bag filled with PPE gowns, gloves, and wipes was hanging on the door. There was not an infection control precaution sign on the door. During an observation on 8/28/24 at 7:59 a.m., resident #16's door had a enhanced barrier precautions sign, but no PPE equipment or PPE supplies were found in the room or bathroom. During an interview on 8/28/24 at 1:06 p.m., staff member L stated she has been active in the infection control position for two weeks, as of 8/28/24, but she had been on medical leave for three months prior. Staff member L stated, I'm piecing infection prevention items back together since returning from medical leave. Staff member L stated she would need to check on the status of PPE supplies not being available for use in resident #16's room. Staff member L stated she would address with staff the reason the PPE supplies were not available in resident #16's room. Staff member L said she would address with staff why they didn't know resident #16 had enhanced barrier precautions, due to a MRSA infection. Staff member L stated resident #37 had enhanced barrier precautions in July (2024) however the infection was resolved prior to the survey. Staff member L stated mandatory staff training and education was provided for all staff at the end of April (2024) on enhanced barrier precautions. No further education had been provided. Review of a facility infection control document, updated 5/3/24, showed a list of nine residents on Enhanced Barrier Precautions. Review of a facility policy titled, Enhanced Barrier Precautions, effective April 17, 2024, showed: . c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	. 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC. . 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. . d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room. .8. Additional epidemiologically important MDROs may include, but are not limited to: a. Methicillin-resistant Staphylococcus aureus (MRSA) . 2. During an interview on 8/28/24 at 1:06 p.m., staff member L stated staff member F had been helping with infection monitoring . while I was gone for three months. Staff member L stated the infection control policies were reviewed on the facility intranet and documented with a timestamp. Staff member L said the older hard copy policies were not updated to show the new review date. Staff member L stated, if there were infections they have a map for outbreaks. Once infections are identified, the mapping would be updated and would allow the facility to track and monitor infections. Staff member L stated the facility surveillance tracking had been completed, but the facility was unable to find the surveillance tracking from March 2024 through August 2024. Review of a facility document, titled, Infection Control Program, with a revision date of February 2020, showed: . The Program . contains all the following required elements of a mandatory Infection Control Program as outlined below: 1. A system for prevention, identification, reporting investigation and control of infections and communicable diseases for all residents, staff, . and is based on the Facility Assessment conducted according to regulatory requirements and following nationally accepted standards; 2. Written standards, policies and procedures for elements of the Program including: a. A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility . All reportable infections are to be reported to [County Health Department] for follow up and tracking . Review of a facility policy and procedure, titled, Health Department Reports, with a revision date of February 2022, showed: . 1. Healthcare providers are mandated to report, in writing or by phone notification, confirmed or suspected cases of specific communicable and occupational diseases as designated by the state public health authorities . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Any time after diagnosis and before discharge, when a patient is diagnosed with one of the reportable diseases, either a written report, electronic report, faxed report, or verbal notification must be made to the local health department .

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on interview and record review, the facility failed to provide standard infection control practices through provision of Pnemococcal immunization for 1 (#34) of 24 sampled residents. Findings include: During an interview on 8/28/24 at 1:06 p.m., staff member L stated the pneumococcal policy was getting updated, but the person responsible for updating it left her employment with the facility. Staff member L stated the facility tried to get immunization records before a resident was admitted . Staff member L stated she didn't know what the exact process of keeping up with immunizations was. Staff member L said staff member F would ask about the resident vaccinations yearly, during the MDS assessment period. Staff member L stated she had access to imMTrax to review the immunization status of residents. Staff member L said accessing imMTrax is done only upon request from staff member F. During an interview on 8/28/24 at 2:26 p.m., staff member F stated staff member N will be taking over immunization review. Staff member N will be in charge of immunizations prior to the scheduled flu clinic. Staff member F stated she generates resident preventive health reports for immunization tracking. Staff member F stated there are six residents who were overdue for the pneumococcal immunization. Nursing staff was planning to give the pneumococcal immunizations after obtaining physician guidance. The vaccinations would be given during the scheduled flu clinic, this fall (of 2024). Review of resident #34's Preventive Health Care Report, with a date range 3/20/24 - 8/27/24, showed resident #34 was not current on her pneumoccocal vaccination. The vaccination guidelines showed recommendations of one dose of PCV20. Review of resident #34's undated immunization summary document, showed, Pneumococcal Conj PCV13 was administered on 3/13/18. According to CDC recommendations, resident #34 should have received one dose of PCV20 or one dose of PPSV23 at least one year after the PCV13 vaccine. Review of a facility policy, titled, Influenza and Pneumococcal Immunizations, revised October 2009, showed: . Each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; and that each resident has the opportunity to receive, unless medically contraindicated or refused or already immunized, the influenza and pneumococcal vaccines. A request was made to the facility on [DATE] for a consent and immunization admission record for resident #34. No document was provided for the resident's Pneumococcal immunization consent, or a declination for resident #34, by the end of the survey.