

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Pioneer Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 200 N Oregon St Dillon, MT 59725	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>44770</p> <p>Based on observation, interview, and record review, the facility failed to provide an environment that was clean, well maintained, and safe for 3 (#s 23, 27 and 40) of 23 sampled residents. This deficiency had the potential to affect all residents in the facility who walk or use wheelchairs in the hallways and areas with baseboard heaters and who reside in the facility. Findings include:</p> <p>1. During an observation and interview on 5/19/24 at 9:59 a.m., resident #27's linens appeared visibly dirty. There were stains on the sheets and his comforter was visibly soiled. Resident #27 stated the CNAs changed the sheets about once a week and sometimes he had to ask them to change them because they were so dirty. Resident #27 said the CNAs were super busy, so he tried not to bother them.</p> <p>During an observation and interview on 5/19/24 at 9:23 a.m., resident #40's linens were visibly dirty with a betadine stain at the foot of the bed. When asked about the stain, resident #40 stated it had been there for two weeks. Resident #40 said sometimes his linens did not get changed for several weeks.</p> <p>During an observation on 5/18/24 at 12:15 a.m., the toilet in the CNA classroom was observed to have urine stains on the porcelain around the bowl and there was a brown stain inside the toilet at the top of the water level all the way around the bowl that was approximately 1.5 inches wide. There was a brownish stain on the bathroom floor.</p> <p>During an observation on 5/20/24 at 10:16 a.m., the doorknob for resident #40's room was falling apart. The ring between the knob and the door was hanging loose, and no longer fixed to the door. The baseboard heaters in the dining area and halls had been damaged by wheelchair foot pedals. There were sharp metal pieces sticking out from the baseboards.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/20/24 at 12:39 p.m., staff member E stated staff could alert him of items requiring maintenance using an electronic system. He stated most of the time things were written in a three-ring binder kept at the nurse's station. He stated he would typically check the book twice a day. He stated sometimes staff and residents would just catch him in his office or in the hall and let him know if anything required maintenance. He was asked by surveyors if he was aware of resident #40's doorknob, he stated he was not but that there had been several doorknobs that had fallen apart. He stated he would go check on it. He was asked if he was aware of the baseboard heaters being damaged. He stated he was, and he had been trying to find a good way to repair them. Staff member E agreed the sharp metal sticking out from the baseboards could be dangerous to residents and was a safety hazard. He stated he tried using Flex Seal on some of the baseboards and felt it worked well. He stated he would work on repairing the other damaged heaters.</p> <p>During an interview on 5/21/24 at 8:48 a.m., staff member F stated her expectations for cleaning rooms and the facility was that the facility should be cleaned just like a hospital. She stated she expected staff would sweep and mop floors, clean sinks and toilets, dust and empty waste bins daily in resident rooms. She stated housekeeping staff was expected to strip the beds and wipe down the beds once a month. Staff member F stated the CNAs were supposed to change the bed linens on resident shower days. Staff member F stated the CNA training room should be cleaned daily and should have a deep clean once a month.</p> <p>2. During an observation on 5/18/24 at 3:12 p.m., resident #23's bathroom floor was visibly dirty and the toilet bowl had a greenish/brown buildup.</p> <p>During an observation on 5/20/24 at 9:45 a.m., resident # 23's bathroom floor appeared to have reddish brown particles around the toilet and along the tub and wall. There was a greenish/brown buildup at the bottom of the toilet, as well as a ring around the bowl. A damp, white tissue became soiled after wiping the area, and the wiped area on the floor appeared cleaner.</p> <p>Review of a facility record book titled Housekeeping/request form on 5/21/24, failed to show broken baseboard heaters or doorknobs written on the list of items requiring maintenance.</p> <p>Review of a facility document titled, Housekeeping Meeting, not dated, showed:</p> <p>Room cleaning EVERYDAY</p> <ul style="list-style-type: none"> o Dust all surfaces including wall hangings, Televisions, tables, shelves, curtain rods, and blinds o Garbage's emptied and wiped down. 6 bags per can o Bathroom surfaces sprayed and cleaned with PINK bathroom cleaner. Sink, shelves, paper towel dispenser, soap dispenser, handrails, towel racks and toilet o Use pumice stone and or toilet brush on the inside of the toilet bowl o Wipe/ scrub around the bottom AND back of the toilet <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770</p> <p>Based on interview and record review, the facility failed to update care plans for 3 (#s 36, 42, and 49) of 23 sampled residents. Resident #36 had repeated behaviors documented and no updates or changes in interventions were made on his care plan resulting in continued behaviors. Residents #42 and #49 had repeated falls documented and no updates or changes in interventions were made on their care plans resulting in repeated falls. Findings include:</p> <p>1). During an interview on 5/21/24 at 9:55 a.m., staff member G stated, the ADON was responsible for updating care plans. He said care plans should be updated every time a resident has a fall, or any time there are new interventions for any focus area in the care plan. He stated nurses were not involved in revising the care plans. Staff member G said the EMR would show a date for every time the care plan was updated. Care plans were revised yearly or more frequently if necessary for resident needs.</p> <p>Review of resident #36's Behavior notes showed, 44 incidents of documented behaviors from 1/2/24 through 5/17/24. Some of the behavior notes included several incidents throughout the day of resident #36 displaying behaviors.</p> <p>Review of resident #36's Care Plan showed, [resident name] has a behavior problem perseverating on leaving the facility, refusing scheduled outside appointments, worries about brother [name] health status, altered perception of staff statements/instructions r/t (Anxiety) All interventions on the care plan showed an initiated date of 4/2/23 and revised date of 4/16/24. There was one intervention that added Seroquel as a medication on 10/27/23, this intervention was also revised on 4/16/24. There were no other revision dates or changes to the care plan.</p> <p>2). Review of resident #49's EMR showed resident #49 had fallen 8 times in seven weeks in the facility; one of those falls resulted in a visit to the ER for a head injury with laceration requiring sutures.</p> <p>Review of resident #49's Care Plan showed, [resident name] is a high-fall risk, she has had actual falls without and with minor injuries, due to poor safety awareness and unsteady gait. There were interventions initiated on 4/1/24 and 4/30/24. There were no revisions to the care plan or other interventions added.</p> <p>46400</p> <p>3. Review of resident #42's nursing progress notes, dated January 2024 - current, showed the resident had 17 falls in a five-month span. Eight of these falls occurred while the resident had an infection and/or was on antibiotics.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #42's care plan, with an initiation date of 2/28/24, showed a focus area of high risk for falls initiated on 2/28/24. All of the interventions for falls were also implemented on 2/28/24. There was a lack of updated interventions related to root cause analysis done on the resident falls after 2/28/24. There was a lack of identification of the pattern related to infections and increased falls.</p> <p>During an interview on 5/21/24 at 10:35 a.m., staff member I stated the facility was aware all staff did not have time to review the care plans or Kardex so there was a verbal report to the aides for any new resident interventions that were implemented. Staff member I stated it was usually staff member C or herself that updated care plans, but all nurses were able to add interventions.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46400</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's dignity and clean appearance by implementing measures or assistance to keep his clothing free of food debris for 1 (#42) of 23 sampled residents. Findings include:</p> <p>During an observation on 5/18/24 at 12:46 p.m., resident #42 was eating lunch in the dining room. He was struggling to navigate the fork to his mouth. Food had fallen off of the fork and was splattered all over his clothes and the nearby floor. Residents around him were wearing clothing protectors.</p> <p>During an observation on 5/19/24 at 1:07 p.m., resident #42 was eating lunch in the dining room. He was struggling with a shaky fork and had fruit salad down the front of his shirt and on his lap.</p> <p>During an interview on 5/20/24 at 1:25 p.m., NF2 stated they weren't complaining, but did wish the facility would offer resident #42 a clothing protector at meals.</p> <p>Review of resident #42's Quarterly MDS with an ARD of 12/1/23, showed under Section GG Functional Abilities and Goals, the resident was marked as independent.</p> <p>Review of resident #42's Significant change MDS, with an ARD of 4/3/24, showed under Section GG Functional Abilities and Goals, the resident had experienced a decline to needing assistance.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400</p> <p>Based on observation, interview, and record review, the facility failed to identify the root cause of falls for the implementation of individualized interventions; and failed to ensure resident care plans were updated with interventions addressing the residents' current medical, physical, and cognitive limitations for 2 (#s 42 and 49) of 2 residents sampled for falls. Findings include:</p> <p>1. During an observation and interview on 5/21/24 at 9:42 a.m., resident #42 was attempting to stand up out of his wheelchair. He was part way in the door of his room. He stepped forward and tripped on the foot pedals of his wheelchair. A member of the survey team reached out to catch resident #42 to keep him from falling to the ground. Resident #42 stated he needed to get his dresser packed. Resident #42 continued to attempt to stand up. Staff member H came to assist the surveyor and stated the resident had already fallen that morning and thanked the surveyor for catching him. Staff member H said it was common for her to have to work both the 300 hall and the 400 hall and there were two residents (#s 42 and 49) who required very close supervision because they fell frequently. Staff member H said resident #42 had his room changed at the facility and kept trying to go back to his old room. He was packing and focusing on getting back to his old room. Staff member H said his behavior made it harder to keep him from falling and made him more impulsive. Staff member H said she wanted to put resident #42 back to bed, but was reluctant for fear of the resident attempting to get up on his own and falling again. Staff member H stated resident #42 was not [cognitively] there enough to use his call light for help.</p> <p>During an interview on 5/21/24 at 10:35 a.m., staff member I stated the staff had a busy morning and hadn't had time to document resident #42's 5/21/24 morning fall in the electronic medical record yet. Staff member I stated they did a verbal round with staff when there were new interventions for residents since not everyone had time to read the care plans or Kardex. Staff member I stated the facility had stopped doing the falling star indicators on resident doors and wheelchairs mentioned in their fall protocol when they were told in the past it was dignity/HIPAA issue.</p> <p>Review of resident #42's nursing progress notes, dated January 2024 - current, showed the resident had 17 falls in a five-month span. Two of these falls resulted in trips to the emergency department for a head contusion and broken nose. Eight of these falls occurred while the resident had an infection and/or was on antibiotics.</p> <p>Review of resident #42's nursing progress notes, dated January 2024 - current, showed the following falls and antibiotic orders:</p> <p>a. Resident #42 had an order for the antibiotic Bactrim twice daily dated 1/27/24 - 2/6/24 for a UTI.</p> <p>- 1/27/24 fall while on antibiotics.</p> <p>- 2/2/24 fall in the bathroom resulting in a left forehead contusion and broken nose. He was sent to the E.R. He was still on antibiotics at this time for a UTI.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an interview on 5/21/24 at 9:42 a.m., staff member H said she did not know if there was a fall committee or any kind of fall prevention program. She stated if there was a fall committee she did not know about it and the CNAs were not involved. Staff member H said she did not know of any interventions specific to residents to help keep them from falling. Staff member H said she did not know where to find interventions and she stated there was no discussion regarding residents and interventions to prevent falls.</p> <p>During an interview on 5/21/24 at 9:55 a.m., staff member G said when a resident falls at the facility, the nurses should do a rapid assessment of the resident if the fall was not witnessed the nurses should start neuro assessments. The neuro assessments should be documented on an assessment sheet and then sent to medical records to be scanned into the resident's medical chart later. Staff member G said staff are supposed to fill out an incident report in the EMR. Staff member G said the nurses are not involved in a fall committee or any meeting where they assist in coming up with interventions specific to resident's needs. Staff member G was not aware of any conversations regarding specific residents and preventing falls. When asked if the residents with a high fall risk should have a star on their door or on their wheelchair as per the fall prevention policy, staff member G stated he was not aware of that.</p> <p>During an observation on 5/20/24 at 1:02 p.m., resident #49 did not have a star on her wheelchair or on her door.</p> <p>During an observation on 5/21/24 at 10:22 a.m., resident #49 was at the nurse's station next to the day room. She was in a wheelchair and was scooting herself to the edge of her wheelchair. She had her hand on the countertop of the nurse's station and attempted to stand up. A staff member who just walked around the corner was able to catch her and assist her back in the chair.</p> <p>During an observation on 5/21/24 at 10:45 a.m., resident #49 climbed out of her wheelchair and stood up, the resident was leaning backwards with her hands on the arm bars of her unlocked wheelchair. There were no staff present. The surveyor intervened and called for staff. The housekeeping supervisor came to assist the resident.</p> <p>Review of resident #49's EMR showed she was admitted on [DATE], she had a fall assessment completed on 4/20/24 after she had four falls. The assessment showed a score of 15 indicating she was a high fall risk. On 5/17/24 another fall assessment was completed after 4 additional falls. The assessment showed a score of 16 indicating she was a high fall risk.</p> <p>The EMR showed documentation of falls on 4/2/24 at 3:15 p.m., 4/13/24 at 11:17 a.m., 4/18/24 at 10:35 a.m., 4/20/24 at 10:30 p.m., 5/13/24 at 3:55 a.m., 5/13/24 at 4:14 a.m., 5/14/24 at 3:15 a.m., and 5/17/24 at 5:23 p.m. The fall on 5/14/24 at 3:15 a.m. resulted in the resident being sent to the emergency department for a laceration on her head requiring sutures.</p> <p>Review of a facility document titled Fall Prevention Program, not dated, showed:</p> <p>.Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls .</p> <p>2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44769</p> <p>Based on observation, interview, and record review, the facility failed to provide behavioral health services for 2 (#s 6 and 36) of 2 residents sampled for behavioral concerns. This deficiency had the potential to lead to psychological harm for resident #s 6 and 36. Findings include:</p> <p>1. A review of a Patient Health Questionnaire-9 (PHQ-9) for resident #6 in the facility's EHR, dated [DATE], showed a score of 12, which is indicative of a moderate depressive disorder.</p> <p>A review of resident #6's care plan showed:</p> <ul style="list-style-type: none"> - Focus: [Resident #6] has depression. [Resident #6] will be free of signs of depression including: exit seeking, agitation, crying, and verbal outbursts with an initiated date of [DATE], and a revision date of [DATE]. - Focus: [Resident #6] has depression r/t Vascular Dementia, Hx CVA without residual deficits, Hx TIA's, PTSD, with an initiated date of [DATE], and a revision date of [DATE]. Goal: I will remain free of s/sx of distress, symptoms of depression, anxiety or sad mood by/through review date. Date Initiated: [DATE] Revision on: [DATE] Target Date: [DATE]. <p>A review resident #6's diagnoses in the facility's EHR, showed:</p> <ul style="list-style-type: none"> - Major depressive disorder, recurrent, moderate. Dated [DATE]. - Post Traumatic Stress Disorder, Unspecified. Dated [DATE] - Anxiety disorder, unspecified. Dated [DATE]. <p>A review of a progress noted in resident #6's EMR, dated [DATE] at 3:59 a.m., showed:</p> <p>Note Text: Resident had several behaviors during this shift. Came out into the hallway several times telling staff to get out of her house, throwing things, trying to hit staff and name calling.[sic]</p> <p>A review of a progress note in resident #6's EMR, dated [DATE] at 6:52 p.m., showed:</p> <p>Note Text: Provider notified of resident suicidal ideation. instructed nursing to do every 15 minute checks and one on one from 6:00 p.m.-12:00 a.m. Every 15 minute checks from [DATE] 12:00 a.m.-8:00 a.m.[sic]</p> <p>On [DATE] at 3:37 p.m., a request was made for mental/behavioral health records for resident #6.</p> <p>During an interview on [DATE] at 4:30 p.m., staff member I stated I know we don't have a mental health evaluation for [resident #6].</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:00 a.m., staff member J stated resident #6 was referred to a counselor yesterday. Staff member J further stated there had not been any mental health consultation or evaluations for resident #6.</p> <p>44770</p> <p>2) During an observation on [DATE] at 9:18 a.m., resident #36 was in his room with the door open; he was on the phone yelling. The resident was yelling loudly in the phone and using profanity. The resident could be heard yelling from the hallway.</p> <p>During an observation on [DATE] at 12:52 p.m., resident #36 was observed shouting at another resident demanding the resident return his check. The other resident did not have resident #36's check.</p> <p>During an interview on [DATE] at 9:26 a.m., staff member I stated, There is no services for counselling or mental health here. [Resident #36] is not receiving any services for his mental health.</p> <p>During an interview on [DATE] at 9:51 a.m., staff member I stated resident #36 had not had a referral for the [NAME] who comes to the facility.</p> <p>Review of resident #36's EMR failed to show notes or referrals for mental health services or behavioral health services.</p> <p>Review of resident #36's Behavior notes showed, 44 incidents of documented behaviors from [DATE] through [DATE]. Some of the behavior notes included several incidents in one note of resident #36 displaying different behaviors throughout the day. Resident #36's behavior notes consisted of yelling, wanting the police called, wanting his doctor called, being concerned his brother had been locked out of the building, thinking his brother died , concerned about his brother's phone, wanting to go home and help his brother, refusing to go to outside appointments, agitation, aggression, and being anxious.</p> <p>Review of resident #36's Care Plan showed, resident #36 was admitted on [DATE]. Under the Focus heading the care plan showed, [resident #36] has a behavior problem perseverating on leaving the facility, refusing scheduled outside appointments, worries about brother [name] health status, altered perception of staff statements/instructions r/t (Anxiety) All interventions for the behavior focus area on the care plan showed an initiated date of [DATE] (one year after the resident was admitted to the facility) and revised date of [DATE]. There was one intervention that added Seroquel as a medication on [DATE], this intervention was also revised on [DATE]. In addition, under the Focus heading the care plan showed, [resident #36] is at risk for abuse due to altercation with another male resident. [resident #36] was the victim. The interventions for risk of abuse were initiated on [DATE] the interventions had no revision dates.</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770</p> <p>Based on interview and record review, the facility failed to provide medical social services for 1 (#36) of 2 residents sampled for behavioral concerns. This deficiency had the potential to negatively impact the resident's psychological and mental wellbeing. Findings include:</p> <p>During an interview on [DATE] at 10:59 a.m., staff member J stated, I have been here about a month and a half, I don't have a degree or anything. I was hired on, to learn as I go. Staff member J stated she would intervene when resident #36 was agitated. She stated she had spoken to the doctor about medication changes to decrease behaviors, but it had not helped with resident #36's behaviors. Staff member J stated resident #36's behaviors had gotten worse since she had worked at the facility. Staff member J stated, There has not been any medical social services for [resident #36]. She said the only changes the facility had made for him was to request the doctor make changes to his medication.</p> <p>A request was made for mental health, and/or behavioral health notes, referrals, visits, or counselling on [DATE] at 4:10 p.m. Staff member I stated there were no documents to provide.</p> <p>Review of resident #36's EMR failed to show notes or referrals for mental health services or behavioral health services.</p> <p>Review of resident #36's Behavior notes showed, 44 incidents of documented behaviors from [DATE] through [DATE]. Some of the behavior notes included several incidents included in one note showing resident #36 displaying different behaviors throughout the day. Resident #36's behavior notes consisted of yelling, wanting the police called, wanting his doctor called, being concerned his brother had been locked out of the building, thinking his brother died, concerned about his brother's phone, wanting to go home and help his brother, refusing to go to outside appointments, agitation, aggression, and being anxious.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770</p> <p>Based on observation, interview and record review, the facility failed to follow diet textures for 2 (#s 13 and 22) of 6 residents sampled for diet textures. This deficiency caused resident #13 to have two documented choking episodes and had the potential to cause resident #22 to have choking episodes or aspiration of food. Additionally, the facility failed to follow a low carbohydrate diet with double portions of protein for 1 (#40) of 1 resident sampled for a controlled carbohydrate diet. This deficiency resulted in an increase in resident #40's blood sugar and caused him to be concerned his healing would be delayed and his ability to discharge home from the facility would be delayed. Findings include:</p> <p>1. During an interview and observation on 5/19/24 at 12:50 p.m., staff member K was preparing lunch trays for the residents. While staff member K was preparing resident #13's meal, she cut up the resident's pork with a knife instead of giving the resident the ground meat as she had for previous plates with soft and bite sized texture ordered. Staff member K stated, I was just told to do this for her because she doesn't like the ground meat. When asked if cutting the pork met the diet texture of Soft and Bite sized she stated she did not know. Staff member K did not perform a fork or spoon pressure test on the meat she cut up with the knife. While staff member K was preparing resident #22's meal she placed a ham sandwich on the resident's tray and cut the sandwich into four sections. Resident #22's diet card said, Soft and Bite sized for the diet texture ordered.</p> <p>During an interview on 5/20/24 at 11:37 a.m., staff member L said meat cut up with a knife and a sandwich cut into four pieces would not qualify as soft and bite sized. He added that bread must be approved by speech therapy. He said the speech therapist would have to approve any changes in diet texture. Staff member L said the diet texture could also be changed by the physician. Otherwise, the diet texture should be followed. Staff member L said the facility was in the process of changing to another classification of diet textures and Soft and Bite sized would be equivalent to the IDDSI (International Dysphagia Diet Standardization Initiative) diet SB6.</p> <p>Review of resident #13's speech therapy notes on 5/17/24 showed, patient with choking episode X 2 on this date. Patient with difficulties tolerating current diet. Patient requires supervision and cueing for swallowing . Current foods/Solids= soft and bite-sized foods SB6. The speech therapy notes failed to show approval for resident #13 to receive meat cut with a knife instead of ground meat.</p> <p>Review of resident #22's speech therapy notes on 5/13/24 showed, Current foods/solids= Soft and Bite Sized foods SB6. Resident #22's speech therapy notes failed to show resident #22 had been approved to receive bread or a sandwich cut into four pieces.</p> <p>Review of resident #13's diet order showed, Mechanical soft . additional directions: soft and bite sized.</p> <p>Review of resident #22's diet order showed, National Dysphagia 2 (mechanical soft) . For (indications for use): soft and bite sized.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a facility provided document titled, 6 Soft and Bite Sized IDDSI diet, showed, food texture for Soft and Bite Sized texture included foods that could be mashed or broken down with the pressure of a fork or spoon. The food should not return to its original form after being mashed by the fork or spoon. Meat that cannot pass the fork or spoon pressure test should be served minced and moist. The document showed, No regular dry bread, sandwiches or toast of any kind.</p> <p>2. During an interview and observation on 5/19/24 at 9:23 a.m., resident #40 stated, the facility does not have a low carb option for food. He stated he is supposed to get a diabetic diet with double protein. Resident #40 said the extra protein was important to him because he had a fractured femur, and the extra protein was ordered to help his body heal. Resident #40's breakfast tray was in his room. The tray had two pancakes, a bowl of cream of wheat, regular syrup, and a cup of coffee. The food order sheet was on the tray, it showed CCHO (Controlled/Consistent Carbohydrate diet), and double protein. Resident #40 said he did not receive any protein with this breakfast. He stated he rarely received double protein and sometimes no protein at all. Resident #40 said his blood sugars had increased since he had been in the facility as well and he felt that was very concerning. He said he felt the increase in his blood sugars was related to the amount of carbohydrates he was served in the facility. Resident #40 said, Every meal is just carbs, carbs, carbs. He said he had not spoken with the dietician since he had been in the facility. He said he was trying to be able to discharge back home and be able to return to his full-time job and having less control of his blood sugar might make his discharge take longer.</p> <p>During an interview on 5/19/24 at 11:24 a.m., staff member M said the facility followed the [NAME] diets. She said if the resident was ordered a CCHO diet they should receive everything on the CCHO diet for that meal. She said the kitchen used diet cards to direct them when serving meals. The diet cards told them what diet the resident should receive, what texture the diet should be served, and if there were any additional instructions, for instance, allergies, dislikes, and if the resident should be given extra protein, double portions, or any other recommendations from the dietician. Staff member M said if the diet card said double protein the resident should receive a double portion of any protein served during the meal.</p> <p>During an interview on 5/20/24 at 11:37 a.m., staff member L stated he typically reviewed resident blood sugars for diabetic patients in the facility. Staff member L stated, I am going to be honest; I have not reviewed his [resident #40] chart or his blood sugars. He said pancakes, cream of wheat, and syrup alone would not comply with a CCHO diet order. Staff member L said double protein is helpful for healing and if a resident is ordered double protein, it would be important for the resident to receive double protein.</p> <p>Review of resident #40's EMR on 5/20/24, showed, resident #40's blood sugars were checked several times a day. His blood sugar in May 2024 was as high as 321mg/dl (normal range for a person with type 2 diabetes is 80mg/dl-130mg/dl fasting, and less than 180mg/dl after eating. According to the American Diabetes Association). A physician H&P written on 3/28/24 three days after the resident was admitted to the facility showed, blood sugars have been ranging 177-204 since admission. A progress note written on 4/26/24 showed, Nursing has raised concerns about high blood sugars over the last few days, as high as 373 this afternoon. Resident #40's EMR failed to show notes from a dietician.</p> <p>Review of a facility provided document titled, Controlled Carbohydrate Diet showed, Individual responses in blood glucose to carbohydrate patterns of meals need to be evaluated by appropriate personnel to determine any needed adjustments in medication or food intake.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44770</p> <p>Based on observation and record review, the facility failed to store food in accordance with professional standards by failing to label and date food stored in the facility's freezer. Findings include:</p> <p>During an observation on 5/19/24 at 11:24 a.m., the following items were observed in the freezer:</p> <p>1 bag of waffles, not in original box, not labeled, and not dated.</p> <p>1 open bag of fish sticks, not in original box, not labeled, and not dated.</p> <p>1 package of sliced meat, not in original container, not labeled, and not dated.</p> <p>1 package of shredded/chopped meat, not in original container, not labeled, and not dated.</p> <p>Review of a facility provided document, titled Food and Nutrition Services 'Use by' Date Guidelines showed:</p> <p>The following is a guide to use when establishing a 'use by' date for food items . The manufacturer's expiration date, when available, is the 'use by' date for unopened items . Guidelines apply, regardless of storage location . Frozen Foods stored in the freezer 'Use by' date 45 days after opening and properly closed.</p>

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44769</p> <p>Based on interview and record review, the facility delayed physical therapy services for a post stroke resident for 1 (#47) of 1 resident sampled for physical therapy services. This deficient practice resulted in the resident not receiving physical therapy for 47 days after admission to the facility. Findings include:</p> <p>During an interview on 5/20/24 at 8:24 a.m., NF1 stated PT let her down. She was starting to walk at [Hospital name] before she came to the facility. NF1 further stated that resident #47 had to be able to stand to get in her wheelchair before she would be able to come home for him to take care of her.</p> <p>During an interview on 5/20/24 at 1:41 p.m. staff member D stated the facility did not have a physical therapy program for the last four years. Staff member D further stated that resident #47 was making progress overall, but not making progress to stand and pivot.</p> <p>During an interview on 5/20/24 at 2:54 p.m., staff member D stated resident #47's initial PT evaluation was 2/12/24 because the facility did not have a physical therapist prior to that.</p> <p>During an interview on 5/20/24 at 3:15 p.m., staff member N stated the best outcome would be achieved for a condition requiring PT if the PT had been initiated upon admission. Ground would be lost if there was a delay in starting PT.</p> <p>During an interview on 5/21/24 at 5:06 p.m. NF4 stated she probably did not put in a PT order [for resident #47] because the facility did not have a physical therapist at the time of her admission.</p> <p>A review of resident #47's EHR showed an admitted [DATE] and a diagnosis of hemiplegia and hemiparesis following a cerebral infarction, Muscle weakness (generalized), and Repeated falls.</p> <p>A review of resident #47's PT progress notes showed a start date for PT of 2/12/24.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400</p> <p>Based on interview and record review, the facility failed to offer pneumococcal vaccinations for 1 (#44) of 5 residents sampled for pneumococcal vaccination or declination. Findings include:</p> <p>Review of resident #44's medical record failed to show the resident had received or declined the pneumococcal vaccination. Resident #44 was admitted to the facility on [DATE].</p> <p>During an interview on 5/21/24 at 9:10 a.m., staff member C stated she was waiting on ImMTrax (Montana Immunization Service) login credentials to verify who had and who still needed various vaccinations.</p> <p>During an interview on 5/21/24 at 10:13 a.m., staff member C stated she was needing to discuss vaccinations with resident #44's POA.</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400</p> <p>Based on interview and record review, the facility failed to offer Covid-19 vaccinations to 1 (#44) of 5 residents sampled for Covid-19 vaccination or declination. Findings include:</p> <p>Review of resident #44's medical record failed to show the resident had received or declined the Covid-19 vaccination. Resident #44 was admitted to the facility on [DATE].</p> <p>During an interview on 5/21/24 at 9:10 a.m., staff member C stated she was waiting on ImMTrax login credentials to verify who had and who still needed various vaccinations.</p> <p>During an interview on 5/21/24 at 10:13 a.m., staff member C stated she was needing to discuss vaccinations with resident #44's POA.</p>