STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275125	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Living Centre	57 Main St Stevensville, MT 59870

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 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. 46400 Based on interview and record review, the facility failed to include a resident's intermittent catheterization on a resident's care plan, for 1 (#2); and failed to create and implement a comprehensive person-centered care plan related to trauma informed care, and the resident became upset related to events which occurred when the resident was in a past war, for 1 (#29) of 18 sampled residents. Findings include: 1. Review of resident #2's nursing progress notes, dated 12/4/24, showed the resident needed to be straight cathed due to an inability to urinate, and the resident had 650 cc of urine output. She was on antibiotics for a UTI. Review of resident #2's nursing progress notes, dated 12/24/24, showed the resident had 750 cc of urine removed via straight cath, after complaints she was unable to urinate. She was taking antibiotics for a UTI. Review of resident #2's physician orders, dated 7/12/24, showed, Check for bladder distention every 6 hours if distended straight cath . Review of resident #2's Urology notes, dated 9/3/24, showed she was seen by [Clinic Name] for intermittent urinary retention. The plan was: CIC and catheterize as needed, recommend sending UA and culture at time of catheterization to rule out infection . If patient requires intermittent cath more than 3 times in a 1 month recommend placement of indwelling Foley catheter and schedule follow-up . [sic] Review of resident #2's care plan failed to show the resident experienced urinary retention, UTIs, or needing the occassional intervention of intermittent catheterization. During an interview on 1/29/25 at 10:30 a.m., staff member D stated the resident only seemed to need to be straight cathed when she had a UTI. She stated this information should be on the care plan and would be added. 44770 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 1/28/25 at 3:04 p.m., staff member I stated she was giving resident #29 a shower one day, and she could not remember the exact day, but stated she sent another CNA to get some clothing for resident #29. When the other CNA arrived with the clothing, she had a red shirt for the resident. Staff member I said resident #29 became very upset. He told her the red shirt reminded him of blood, and it made him think of his time in Vietnam. She said he told her he would not wear the red shirt at all and preferred to wear black clothing. She stated she wished she would have been aware the red shirt would trigger his PTSD about the war in Vietnam. She said she would normally find that information on a care plan but stated she was not aware at the time the red shirt would upset him. During an interview on 1/29/25 at 10:37 a.m., staff member J stated she would usually do an initial questionnaire with new residents and ask them about their family life and things in their past. She stated she did not ask specifically about traumatic experiences, but if the resident shared something she felt was a trigger for PTSD (Post Traumatic Stress Disorder) or trauma response it should be added to the Comprehensive Care Plan. She stated she would also share the information with nursing so they could add their own interventions to the care plan as well. Review of resident #29's Comprehensive Care Plan, printed on 1/29/25, lacked a focus area related to resident #29's PTSD and lacked interventions to avoid things that could trigger his PTSD which would be upsetting for the resident.

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NAME OF PROVIDER OR SUPPLIER The Living Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 57 Main St Stevensville, MT 59870	

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 44770 Based on interview and record review, the facility failed to provide trauma informed care for a resident with PTSD, and the resident voiced having nightmares, and was identified as having hallucinations related to his time in Vietnam; and the facility did not identify concerns related to the PTSD and ensure a care plan was in place for staff to be able to meet his needs sufficiently (refer to F656 Comprehensive Care Plan), for 1 (#29) of 1 sampled resident for trauma informed care. Findings include: During an interview on 1/29/25 at 1:33 p.m., resident #29 stated, The work I do is classified by the federal government. I go on scary missions and crawl on my hands and knees in the jungle slitting the throats of the enemy. I don't like to do it, but I don't want them to sneak in and kill us in the night. I served in Vietnam. After I left Vietnam, they bombed all of them, and I think all the guys I worked with got killed. All of those thoughts have left me with bad nightmares, and it is awful. I was stuck out in the jungle looking for the enemy, I had to slit their throats because no one else would do it. During an interview on 1/28/25 at 3:04 p.m., staff member I stated she would take care of resident #29 when he would come to the shower. She stated there was an occurrence one time with resident #29, and she could not remember the exact date. Staff member I stated she had another CNA bring her some clothes for resident #29 after she had given him a bath. The other CNA arrived with a red shirt, and resident #29 got very upset. Staff member I stated resident #29 told her the red shirt reminded him of blood, and he would not allow her to put that shirt on him. She said she was aware he had PTSD, but she was not aware of anything that would tell her what things might trigger his PTSD. She stated she would not have tried to put the red shirt on him if she had known it would upset him and trigger his PTSD. During an interview on 1/29/25 at 10:14 a.m., staff member C stated she did not know if the facility had a trauma informed care assessment. She stated she knew resident #29 had a PTSD diagnosis, and the diagnosis was not new. Staff member C stated she was unaware of how resident #29's PTSD was triggered and stated she did not know who would add that to the resident's care plan. She stated she thought maybe the activities director would know. During an interview on 1/29/25 at 10:37 a.m., staff member J stated she would do an initial interview with all residents to find out family history and some other questions for new residents. She stated she did not have a formal trauma informed care assessment. Staff member J said she would typically ask the residents if they had anything that would make them sad or angry. She said those questions would usually allow her to find out if the resident had anything that would trigger them emotionally. She stated she did not ask the residents directly about past traumatic events. Review of resident #29's nursing progress note, dated 1/22/25 at 11:51 a.m., showed resident #29 was more confused than normal, and he was hallucinating about his experiences in Vietnam in gruesome detail. Review of resident #29's comprehensive care plan, printed on 1/29/25, failed to show a focus area reflecting resident #29 had PTSD, or if he had any triggering factors, related to his PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Trauma-Informed and Culturally Competent Care, revised August 2022, showed: Purpose . To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. .'Trauma-informed care' is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. .Resident Screening 1. Perform universal screening of residents, which includes a brief, non-specialized identification of exposure to traumatic events. .Resident Assessment .2. Resident assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. Resident Care Planning 1. Develop individualized care plans that address past trauma in collaboration with the resident and family as appropriate. 2. Identify and decrease exposure to triggers that may re-traumatize the resident .