STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275127	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweet Memorial Nursing Home	125 Airport Rd Chinook, MT 59523

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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 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 51133 Based on interview and record review the facility failed to provide a copy of the baseline care plan to the resident or resident's representative for 1 (#20) of 12 sampled residents. Findings include: During an interview on 12/2/24 at 3:08 p.m., resident #20 stated she did not receive any information or communication regarding her baseline care plan from the facility. During an interview on 12/3/24 at 4:10 p.m., NF1 stated she had not received any communication from the facility regarding resident #20's baseline care plan. Review of resident #20's medical record lacked documentation or evidence the baseline care plan was provided to the resident, or the resident's representative. A request was made on 12/4/24 at 1:08 p.m. for documentation regarding the provision of a copy of the baseline care plan, which was to be given to resident #20 and NF1. There was no information or documentation provided prior to the end of the survey.

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 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. 51133 Based on interview and record review, the facility failed to create a comprehensive resident centered care plan for 1 (#20) of 12 sampled residents. Findings include: During an observation on 12/2/24 at 3:08 p.m., resident #20 was observed to have broken teeth in her lower jaw. Review of resident #20's Social Service History & Initial Assessment, dated 9/10/24, showed, . 13. Are you having any dental problems? The response was marked, A. Yes . 13a. If yes, specify: broken and decayed teeth . During an interview on 12/4/24 at 12 :47 p.m., staff member C stated when a resident was assessed to have broken or decayed teeth it would be care planned. Review of resident #20's care plan, dated 9/12/24, lacked any documentation related to broken or decayed teeth or dental services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49554 Based on observation, interview, and record review, the facility failed to revise an individualized comprehensive care plan to reflect the discontinuation of a catheter for 1 (#18); the use of oxygen for 1 (#15); the use of bed rails for 3 (#s 12, 18, and 27) of 12 sampled residents; and failed to involve the resident or the resident's representative in the care planning process for 1 (#20) of 12 sampled residents. Findings include: 1. During an observation on 12/2/24 at 3:14 p.m., resident #18 was sleeping in her bed and did not have a catheter in place. Review of resident #18's physicians order, dated 11/12/24, showed, Begin bladder training, Clamp for 2 hours, unclamp for 2 hours. After 24-48 hours, discontinue the foley catheter in the morning. Dx: Foley catheter, TTWB as 'ok'd' by ortho. [sic] Review of resident #18's care plan, with a revision date of 7/29/24, showed, The resident has Foley Catheter: s/p repair of left leg fracture and impaired mobility. [sic] Resident #18's comprehensive care plan failed to show the removal of resident #18's catheter. 2. During an observation on 12/2/24 at 2:43 p.m., resident #15 was seen wearing oxygen while in bed. The nasal cannula was on the resident's forehead and not in his nose. Resident #15 was sleeping at the time. During an observation on 12/3/24 at 8:27 a.m., resident #15 was in his room and was having difficulty breathing, and the resident did not have oxygen on. Resident #15 stated he should have oxygen on. Review of resident #15's care plan failed to show when and how much oxygen resident #15 should have been receiving. 3. During an observation on 12/2/24 at 2:37 p.m., resident #27's bed had two, half bed rails, attached to it. During an observation on 12/2/24 at 2:49 p.m., resident #12's bed had two, half bed rails, attached to it. During an observation on 12/2/24 at 3:14 p.m., resident #18's bed had two, half bed rails, attached to it. Review of resident #s 12, 18, and 27's care plans failed to show the use of bed rails or their purpose. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/5/24 at 7:51 a.m., staff member B stated, The interdisciplinary team is supposed to update the care plans. I have been doing them, and I know they are needing some work. The facility is looking to hire a new director of nursing, and I will be able to go back to doing MDSs and care plans. Yes, if a catheter was discontinued it should reflect that in the care plan and bed rails and oxygen should also be care planned. 51133 4. During an interview on 12/2/24 at 3:08 p.m., resident #20 stated she had not been asked about her care plan, and she had not contributed to the care planning process. During an interview on 12/3/24 at 4:10 p.m., NF1 stated she had not been contacted or received any communication from the facility regarding resident #20's plan of care. Review of resident #20's EHR lacked any documentation about the resident's or resident's representative involvement in the care planning process. During an interview on 12/4/24 at 12:57 p.m., staff member B stated a care plan meeting was not held for resident #20 after the development of the comprehensive care plan. Review of the resident #20's comprehensive care plan, dated 9/12/24, showed the resident was admitted to the facility on [DATE]. A request was made on 12/4/24 at 1:08 p.m., for the care plan meeting documentation and invite for resident #20. Nothing was received by the end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51133 Based on observation, interview, and record review, the facility failed to identify and assess wheelchair positioning needs for 1 (#20) of 12 sampled residents. This deficient practice caused the resident discomfort due to a poor fitting wheelchair. Findings include: During an interview on 12/2/24 at 3:08 p.m., resident #20 stated her wheelchair was too narrow, and the oxygen tank was positioned on the back of her wheelchair causing her discomfort. During an interview on 12/3/24 at 10:12 a.m., when asked if she had informed anyone of the pain, resident #20 stated she had informed the CNAs. During an interview on 12/4/24 at 11:23 a.m., staff member E said she had not had any communication or awareness of resident #20 caused by her poorly fitted wheelchair. During an interview on 12/5/24 at 8:16 a.m., staff member L stated resident #20 had informed her of pain from the position of the oxygen tank on her wheelchair. Staff member L stated she had informed the maintenance department regarding the resident's wheelchair. During an interview on 12/5/24 @ 8:47 a.m., staff member K stated, Today is the first time I am hearing of it (wheelchair maintenance). During an interview on 12/5/24 at 8:51 a.m., staff member B stated a referral to therapy was made when there was a concern related to wheelchair fitting. Review of resident #20's physical therapy initial examination, dated 9/10/24, showed resident #20 was not evaluated for proper wheelchair positioning.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 51133 Based on observation, interview, and record review, the facility failed to ensure a resident received proper foot care for 1 (#20) of 12 sampled residents. The deficient practice resulted in the resident experiencing pain due to a callus. Findings include: During an interview on 12/2/24 at 3:08 p.m., resident #20 stated she had pain in her left foot because of a callus. Resident #20 stated the facility had done nothing about it. Review of resident #20's progress note, dated 9/6/24, showed, . There is a callus located at mid plantar surface of the left foot. The foot clinic has been treating the callus most recently and resident states they wanted [podiatrist name] to evaluate the residual callus . During an observation on 12/4/24 at 8:25 a.m., there appeared to be a callus on the bottom of resident #20's left foot. Review of resident #20's physician order, dated 9/9/24, showed . Podiatry appointment/consult for callus on pad of L foot . During an interview on 12/4/24 at 11:14 a.m., staff member D stated she scheduled resident appointments after the doctor entered an order for a consult. The consult was not scheduled to address the resident's foot callus.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652 Based on observation, interview, and record review, the facility failed to ensure an as needed antipsychotic medication was limited to 14 days unless evaluated by the physician, and reordered, for 1 (#29) of 5 sampled residents reviewed for unnecessary medications. Findings include: During an observation and interview on 12/3/24 at 8:53 a.m., resident #29 was sitting in her room. She stated she liked to clean and cook. Resident #29 stated she knew she was not at home and did not know why. Resident #29 stated she lived alone prior to coming to the facility. Review of resident #29's EHR showed the resident was admitted to the facility on [DATE], with diagnoses of dementia with other behavioral disturbance, anxiety, and depression. Review of resident #29's physician orders, dated 9/20/24, showed an order for olanzapine 2.5 mg twice daily, as needed, for agitation. The order did not contain a duration or stop date. Review of resident #29's MAR, dated September of 2024, showed the resident received six doses of olanzapine during September. Review of resident #29's MAR, dated October of 2024, showed the resident received 16 doses of olanzapine during October. Review of resident #29's MAR, dated November of 2024, showed the resident received five doses between 11/1/24 and 11/10/24. No doses of the olanzapine were documented as given from 11/10/24 through 11/30/24. Review of resident #29's MAR, dated December of 2024, showed no doses of the as needed olanzapine were given during December. Review of resident #29's pharmacy progress note, dated 10/21/24, showed the order for as needed olanzapine needed to be reordered every two weeks. Review of resident #29's pharmacy progress note, dated 11/11/24, failed to show the olanzapine had been reordered every 14 days, as recommended, on the October monthly medication regimen review. During an interview on 12/4/24 at 12:30 p.m., staff member E stated she was aware of the 14-day limit on as needed psychotropic medications. When asked why the olanzapine for agitation was not reordered after 14 days, staff member E stated she did not document she wanted the medication continued. Staff member E stated she thought the EHR system automatically discontinued as needed psychotropic medications after 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 9:12 a.m., staff member F stated she was responsible for the monthly medication regimen reviews. Staff member F stated she was aware of the 14-day limit on as needed psychotropic medications. Staff member F stated she was not sure why she did not mention the need to reorder every 14 days on the medication review done in November. Review of the facility's policy titled, Psychotropic Medication Use, not dated, showed, . For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41652 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than 5% for 3 (#s 5, 23, and 30) of 19 sampled and supplemental residents. The calculated medication error rate was 8.16%. Findings include: 1. Review of resident #30's MAR, dated 12/4/24, showed the resident was supposed to be receiving 1 ml (50 mg) of a gabapentin 250 mg/5 ml liquid, in the morning. During a medication administration observation on 12/4/24 at 7:35 a.m., staff member G prepared the gabapentin medication for resident #30. The medication bottle had a label which showed the strength of the gabapentin was 250 mg/5 ml. Staff member G used a 1 ml syringe and filled the syringe to the 0.1 ml line. Staff member G put the 0.1 ml of gabapentin liquid into a drinking cup and added water. Staff member G gave the cup to resident #30, and the resident drank all the mixture. When asked what size syringe was used, staff member G pointed to a 1 ml syringe which was stored in the medication cart. After being shown the packaging for the syringe, staff member G stated, Oh. I'm sorry. So, I need to give another 0.9 ml. Staff member G then filled a 1 ml syringe to the 0.9 ml line, mixed it with water and administered the remaining 0.9 ml of gabapentin liquid to resident #30. 2. Review of resident #5's MAR, dated 12/4/24, showed the resident was supposed to receive vitamin B-12 - 5000 mcg in the morning. During a medication administration observation on 12/4/24 at 7:46 a.m., staff member G removed one tablet from a bottle of over-the-counter vitamin B-12 - 500 mcg per tablet label. Staff member G administered the vitamin B-12 - 500 mcg tablet to resident #5. During a follow-up observation and interview on 12/5/24 at 10:45 a.m., when asked to identify the correct medication bottle for resident #5's vitamin B-12, staff member H located the bottle of vitamin B-12 - 500 mcg per tablet. When asked to confirm the correct dose of vitamin B-12 to be given to resident #5, staff member H stated, I don't suppose we are giving 10 of these (500 mcg times 10 tablets equals 5000 mcg) to one resident. 3. During a medication administration observation and interview, on 12/5/24 at 7:48 a.m., staff member H stated she was holding two of resident #23's medications due to a systolic blood pressure less than 110 mmHg. Staff member H stated she was holding amiodarone 100 mg and furosemide 20 mg. Review of resident #23's MAR, dated 12/5/24, showed a morning blood pressure of 106/56. Review of a facility standing order, dated 2/22/22, showed, . 2. If the blood pressure systolic is <110 (unless otherwise noted) needs to have BP (medication) held, As well as lasix (furosemide) & bumex. Review of resident #23's Medication Admin (administration) Audit Report, dated 12/5/24, showed the amiodarone 100 mg was given at 7:49 a.m., and the furosemide 20 mg, was given at 7:50 a.m. on 12/5/24. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 12/5/24 at 10:46 a.m., staff member H stated she did hold the amiodarone and furosemide but must have forgotten to correctly document the medications were held. Staff member H stated she needed to go back into the medication administration module in the EHR and document the two medications as held because of a systolic blood pressure less than 110 mmHg.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51133 Based on observation and interview, the facility failed to discard numerous containers of Half and Half stored in the facility's walk-in cooler, by the use by date. Findings include: During an observation on 12/4/24 at 8:05 a.m., 11 cartons of Half and Half, with a use by date of 12/3/24, were observed on the top shelf, to the right of the entrance, in the walk-in cooler. During an observation on 12/5/24 at 8:07 a.m., eight cartons of Half and Half, with a use by date of 12/3/24, were observed on the top shelf, to the right of the entrance, in the walk-in cooler. During an interview on 12/5/24 at 8:09 a.m., staff member I said dairy products should have been discarded by the use by date.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 51133 Based on observation and interview, the facility failed to provide proper oversight for the use of personal refrigerators in a resident's rooms for 3 (#s 1, 3, and 4) of 3 sampled residents with personal refrigerators. The deficient practice put any resident with a personal refrigerator at risk for consuming food not stored at safe temperatures and consuming outdated food. Findings include: During an observation on 12/3/24 at 8:27 resident #4's personal refrigerator contained no means to measure the temperature of the refrigerator. The freezer contained an unidentified substance in a clear plastic bag that was not labeled or dated. The freezer had a thick layer of ice built up inside and outside of the freezer compartment. There was an unidentified food item wrapped in a napkin in the refrigerator door which did not have a label or date. There was a food item wrapped in brown deli paper with no label or date. There were two green, plastic bags, which contained what resembled fruit which were not labeled or dated. A request was made on 12/3/24 at 1:10 p.m. for the facility's personal refrigerator policy. There was no information received prior to the end of survey. During an observation on 12/4/24 at 10:00 a.m., resident #1's personal refrigerator did not have a temperature gauge inside of the refrigerator to measure the temperature. There was granola bar in an opened wrapper not dated or labeled. During an observation on 12/4/24 at 10:04 a.m., resident #3's personal refrigerator did not have a temperature gauge to measure the temperature or to ensure the temperature was maintained at a safe level. During an interview on 12/4/24 at 10:07 a.m., when asked who managed the personal refrigerators in resident's rooms, staff member M stated, I guess we (housekeeping department) do. When asked how it was managed staff member M stated the housekeeping supervisor did it. When asked what happened when the housekeeping supervisor was not in the facility staff member M stated, I don't know. During an interview on 12/5/2024 at 10:07, staff member A stated she did not know how many residents had personal refrigerators in their room, and could not explain how they were managed for food safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41652 Based on observation and interview, the facility staff failed to perform hand hygiene when passing medications to residents for 3 (#s 13, 21, and 23) of 19 sampled and supplemental residents. Findings include: During an observation in the main dining room, on 12/5/24 at 7:45 a.m., staff member H administered medications to resident #13. After completion, staff member H returned to the medication cart and began the preparation of medications for another resident. Staff member H did not perform hand hygiene between residents. During an observation on 12/5/24 at 7:48 a.m., staff member H prepared the medications for resident #23. Staff member H administered the resident's medications, returned to the medication cart, and began preparation of medications for another resident. Staff member H did not perform hand hygiene between residents. During an observation on 12/5/24 at 7:55 a.m., staff member H prepared the medications for resident #21. After administering the resident's medications, staff member H returned to the medication cart and began preparation of medications for another resident. Staff member H did not perform hand hygiene between residents. During an interview on 12/5/24 at 8:00 a.m., staff member H stated she periodically washed her hands. Staff member H stated she did not touch the pills with her hands, so did not have to perform hand hygiene between residents. When told she was observed touching the resident's eating utensils and dishes, when assisting them with eating during the medication pass, staff member H stated she should have been performing hand hygiene between residents.

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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. 41652 Based on interview and record review, the facility failed to ensure residents were screened for the pneumococcal vaccines (Prevnar 13, Prevnar 20, and PPSV23), and failed to offer or obtain a declination for the vaccines, for 2 (#s 16 and 27) of 5 residents sampled for immunizations (influenza, COVID-19, and pneumococcal). Findings include: 1. Review of resident #27's vaccination history, not dated, failed to show the resident received any pneumococcal vaccines. During an interview on 12/5/24 at 9:27 a.m., staff member J stated she had only been responsible for resident immunizations for two months. Staff member J stated she did not have any other information regarding the offering, receipt, or declination of any of the pneumococcal vaccinations, since the resident's admission to the facility, on 10/30/23. 2. Review of resident #16's vaccination history, not dated, showed the resident received the Prevnar 13 vaccine on 1/14/20. The history form failed to show either the Prevnar 20 or the Pneumovax 23 was offered, given, or declined by the resident or their representative. During an interview on 12/5/24 at 9:27 a.m., staff member J stated she had only been responsible for tracking resident immunizations for the previous two months. Staff member J was not able to explain why the recommended pneumococcal vaccines were not offered or declined by the resident.