STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275134	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Deer Lodge	1100 Texas Ave Deer Lodge, MT 59722

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48261 Based on interviews and record review, the facility failed to refund the resident or resident representative refunds within 30 days from the resident's date of discharge from the facility for 2 (#s 1 and 2) of 2 sampled residents for refunds. This practice had the potential to affect any residents discharging with a refund due. Findings include: Review of resident #1's facility provided financial record showed resident #1's date of discharge was 1/25/24. A refund of $2,000.00 was requested to be refunded to resident #1's representative. The issue date of the refund check sent to resident #1's representative was 3/18/24. This refund was issued 53 days after the date of discharge. Review of resident #2's facility provided financial record showed resident # 2's date of discharge was 3/21/24. A refund of $2,655.00 was requested to be refunded to resident #2's representative. The issue date of the refund check sent to resident # 2's representative was 5/1/24. This refund was issued 41 days after the date of discharge. During an interview on 7/15/24 at 10:30 a.m., staff member A stated the facility was changing finance companies during the processing of resident #2's refund. Staff member A stated the refund was late. During an interview on 7/16/24 at 3:27 p.m., staff member A stated resident # 1's refund was late. Staff member A stated there were no other residents with refunds in the last six months. A review of the facility's policy, Conveyance of Resident Funds Upon Death, reflected, Upon the death of a resident with personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48261 Based on interviews and record review, it was identified the facility had a system breakdown when a new CNA was hired and left alone prior to the end of the new hire orientation period, and the employee did not have the necessary competencies, skills, or supervisory oversight; and, the employee failed to provide incontinence care, resulting in neglect, for 5 (#s 5, 6, 7, 8, and 9) of 14 sampled residents. The neglect of care increased the risk of skin breakdown for those residents. Findings include: A review of a facility reported incident, dated 5/9/24, reflected six residents were not changed and had dried bowel movement or urine, or their bed was wet, with urine. Staff member E was implicated as the staff member who neglected to provide resident care when he failed to complete peri care for the six residents. The facility reported incident findings showed staff member E failed to complete rounds with oncoming staff and was no longer employed by the facility. During an interview on 7/16/24 at 3:40 p.m., staff member E stated, I had 23-24 patients by myself. I was supposed to be training, but my trainer called off, so they just left me all by myself, with no help. The nurse wouldn't help and the CNA on the other unit was barely able to care for her patients, much less help me. I had so much to do, I was exhausted by the end of my shift. I made some rounds but not all of them. I just got a call from a lady saying I no longer worked there (the facility). They (facility management) never even asked for my statement, just fired me. During an interview on 7/16/24 at 4:43 p.m., staff member C stated she had concerns regarding staff member E's employment history. Staff member C stated staff member E did not know what a lift was, did not know things a veteran cna should know. Staff member C stated she asked staff member D about his CNA license and verified it was current, but she, knew things seemed off. Staff member C stated it was daunting to find help when call offs come in late in the day. Staff member C stated she stayed to help with laydowns (putting residents in bed), but she could not work 24/7, so she notified the DON on the night of 5/8/24 at 9:50 p.m., that she had no one to cover the night shift and staff member E would be working the unit alone. During an interview on 7/16/24 at 6:31 p.m., staff member F stated she was not aware staff member E was a trainee. Staff member F stated she was working the other hall and thought staff member E appeared busy. Staff member F stated she did hear staff member E complaining he had not had a break or a lunch. Staff member F stated no management was at facility during her shift, and the only staff present were two nurses, staff member E and herself. Staff member E stated, I'm old, I didn't want to run 200 hall too. I had my own people to take care of. During an interview on 7/16/24 at 6:38 p.m., staff member G stated staff member E, was really new. He said he was experienced, but he was not, and that was obvious to everyone. He was not doing his job, and managed to look busy, but apparently not doing his (resident) check and changes. Then he (staff member E) refused to do walking rounds at shift change and just left. I have mixed feelings because he lied about his experience, but he also didn't get all the training. His trainer (staff member J) was even upset they let him (staff member E) go too. Staff member J didn't think they gave him enough training, nor did I. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's, May-24 schedule, reflected staff member E was scheduled to be on orientation on 5/8/24, with staff member J as the trainer. The schedule reflected staff member J called off on 5/8/24. A review of staff member E's Employment Application, dated 4/19/24, reflected no references, and only one place of previous employment. This surveyor called the number listed on the application for the previous employer, and found the number was not a place of employment. During an interview on 7/17/24 at 8:26 a.m., staff member D stated she did not know where the reference check documents were for staff member E. Staff member D stated she would normally keep the reference checks in the employee's file, but she was not able to find one for staff member E. A review of staff member E's Nurse Aide Skill Competency Checklist, dated 4/26/24, All competency line items were lined through as completed and signed by staff member C. Staff member C had a note on the bottom reflecting, needs orientation alot corrections [sic]. The document was not signed by staff member E.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 48261 Based on interviews and record review, the facility failed to thoroughly investigate allegations of neglect, misappropriation of resident property, and abuse for 7 (#s 3, 4, 5, 6, 7, 8, and 9) of 14 sampled residents. This practice increased the risk of ongoing neglect, abuse, or misappropriation, for any resident who was found to have been allegedly neglected, abused, or a victim of misappropriation of property. Findings include: 1. A review of a facility reported incident, dated 11/15/23, reflected resident #3 was missing a piece of art on a poster. The findings on the report showed the poster was given to a staff member by resident #3. The police were notified, and a police report was filed. During an interview on 7/16/24 at 8:37 a.m., staff member A stated, No resident interviews were done. A police report was filed, so I let them handle it (the investigation). Staff member A stated, I did hear rumors a few weeks later about a staff member accepting the poster, so I called her in right away and told her she couldn't take gifts from residents. I told her she had to go home and get the poster and return it to the resident. A review of a facility provided document, [City] Police Department Case report, dated 11/15/23, reflected the initial report was reported by staff member A. The report stated a necklace (Pegasus shaped) was stolen from resident # 3's room. The report reflected the officer asked staff member A to inform him of any new information that may arise. 2. A review of a facility reported incident, dated 5/9/24, reflected residents #s 4, 5, 6, 7, 8, and 9 were not changed and had dried bowel movement or urine, or their bed was wet, with urine. Staff member E was implicated as the staff member who neglected resident care needs by failing to complete peri care for the six residents. The facility reported incident findings showed staff member E failed to complete rounds with oncoming staff and was no longer employed by the facility. During an interview on 7/16/24 at 8:37 a.m., staff member A stated the facility staff did not complete skin checks for the residents affected after the incident (for neglect of care) and did not interview other residents to determine if others were neglected, or to what extent. Staff member A stated the employee involved was not interviewed. 3. A review of a facility reported incident, dated 7/2/24, reflected resident #4 stated she was pushed onto the bed by a staff member and told she could not get up or leave her room. During an interview on 7/16/24 at 8:23 a.m., staff member A stated the facility did not interview other residents receiving care from the employee accused of abusing resident #4. Staff member A stated, The old DON just didn't do it.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48261 Based on interviews and record review, the facility failed to provide to provide necessary staff training for a new employee, and ensure the employee was competent, and then provide sufficient supervision and assistance, to meet resident care needs, for 5 (#s 5, 6, 7, 8, & 9) of 14 sampled residents. This failure led to neglect of care for the residents. Findings include: A review of a facility reported incident, dated 5/9/24, reflected six residents were not changed during the night of 5/8/24 and had dried bowel movement or urine, or their bed was wet with urine, on the morning of 5/9/24. Staff member E was implicated as the staff member who neglected care and failed to complete peri care for the six residents. The facility reported incident findings showed staff member E failed to complete rounds with oncoming staff and was no longer employed by the facility. During an interview on 7/16/24 at 3:40 p.m., staff member E stated, I had 23-24 patients by myself. I was supposed to be training, but my trainer called off, so they (facility management) just left me all by myself, with no help. The nurse wouldn't help, and the CNA on the other unit was barely able to care for her patients, much less help me. I had so much to do, I was exhausted by the end of my shift. I made some rounds but not all of them. I just got a call from a lady saying I no longer worked there (the facility). They (facility management) never even asked for my statement, just fired me. During an interview on 7/16/24 at 4:43 p.m., staff member C stated staff member E did not know what a lift was, did not know things a veteran CNA should know. During an interview on 7/16/24 at 6:38 p.m., staff member G stated staff member E, was really new. He said he was experienced, but he was not and that was obvious to everyone . he also didn't get all the training. Staff member J didn't think they gave him enough training, nor did I. A review of the facility's, May-24 schedule, reflected staff member E was scheduled to be on orientation on 5/8/24, with staff member J as the trainer. The schedule reflected staff member J call off on 5/8/24. A review of staff member E's, Nurse Aide Skill Competency Checklist, dated 4/26/24, All competency line items were lined through as completed and signed by staff member C. Staff member C had a note on the bottom reflecting, needs orientation a lot corrections [sic]. The document was not signed by staff member E.