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	09/19/2024

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on interviews and record reviews the facility failed to allow the residents a choice for their attending physician for 3 (#s 2, 3, and 4) of 3 sampled residents for physician services. Findings include: During an interview on 9/17/24 at 3:22 p.m., resident #2 said he did not want to see staff member C as his physician. Resident #2 stated he told staff member C he did not want her to be his physician on multiple occasions. Resident #2 said staff member C told him he did not have a choice because he was a VA (Veterans Administration) resident. Resident #2 said he had a right to be able to choose his physician, and the facility would not honor that right. During an interview on 9/18/24 at 10:25 a.m., resident #2 said NF1 was his physician and staff member C kept changing the orders NF1 wrote for him. NF3 was in the room, and she said she would see resident #2 weekly. She stated she did not understand why the facility would not let NF1 be the primary care provider for resident #2. NF3 said she knew residents had a right to choose their own physician. During an interview on 9/18/24 at 3:51 p.m., staff member C said she was resident #2's physician. She said resident #2 did not have a choice of primary care physician because he was a VA resident, and it was a requirement of his contract with the VA to be seen by staff member C. Staff member C stated he was allowed to switch to a different physician, but he would either be required to move to a different facility, or he would lose his VA benefit if he was not seeing a VA affiliated physician. She said if that happened, he would have no way to pay for his stay, and then he would be kicked out of the facility. Staff member C said she was the primary care provider for all residents in the facility. She said it just made things easier for the residents to switch them all to her care when they were admitted to the facility. During an interview on 9/18/24 at 12:15 p.m., staff member D said resident #2 told her he did not want staff member C to be his physician. She said all the residents at the facility had to have staff member C as their primary care physician because she was also the medical director. Staff member D said resident #2 wanted NF1 to be his primary care provider. During an interview on 9/18/24 at 4:30 p.m., resident #3 said he was not given a choice of physician when he was admitted . He said he would have really liked having a choice. Resident #3 said staff member C was assigned to him when he was admitted . (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/18/24 at 4:53 p.m., resident #4 said he was not given a choice of physician when he was admitted . He said he did not know he had the right to choose his primary care provider. Resident #4 stated, I would have loved to keep my regular doctor, but they told me when I came here that I had to see the doctor here. During an interview on 9/19/24 at 8:38 a.m., staff member A said all residents, including short term local residents, were always switched from their primary care physician to staff member C. During an interview on 9/19/24 at 8:42 a.m., staff member B said all residents, on admission, sign the residents rights which show they have a right to choose their physician. Staff member B stated when she would do an admission, she would explain to the resident how convenient it was to have staff member C as their physician. Staff member B said the residents would always agree to have staff member C as their primary care physician in the facility. She said VA residents do not have a choice. During an interview on 9/19/24 at 9:08 a.m., staff member F said she knew residents have the right to choose their own physician, and she knew the facility was required to help find options if the resident did not want staff member C as their primary care provider. Staff member F said she had worked for the facility for about [AGE] years, and she could not remember a time when any resident had chosen a primary care physician other than a provider employed by the facility. During an interview on 9/19/24 at 9:17 a.m., staff member G said she had not been with the facility very long, but she had conducted four admissions. Staff member G said she was taught to read the resident rights, verbatim, to the residents or resident representatives upon admission. She said she was aware residents should have the right to choose their physician, but she said all of the residents were switched to staff member C when they were admitted . During an interview and record review on 9/18/24 at 3:50 p.m., staff member C provided a document she identified as the VA contract for resident #2 and stated, .(she wanted to) straighten a few things out . Staff member C stated the VA contract was proof she was required to be resident #2's primary care physician. Review of the provided VA document, dated 8/10/23, showed: a fax from Montana VA Healthcare Services to the facility. The contract showed resident #2's assigned primary care provider was NF4. The document did not show resident #2 was required to choose staff member C for his primary care provider. Review of a facility provided document titled, Exhibit B Resident Rights, not dated, showed, Each resident shall have the right: .To have free choice of providers of medical services, such as physician and pharmacy .

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 44770 Based on interview and record review the facility failed to allow free access to visitors for 1 (#2) of 2 sampled residents. Findings include: During a telephone interview on 9/18/24 at 8:46 a.m., NF2 said she came to visit resident #2 on 9/4/24 for his weekly hospice visit, and a staff nurse accompanied her to resident #2's room. The staff member told NF2 she was no longer allowed to visit resident #2 without a facility staff member present at all times. During an interview on 9/18/24 t 10:25 a.m., NF3 said she came to visit resident #2 and was told she had to have a facility staff member with her while she was visiting resident #2. She said the hospice CNA came to see resident #2, and she was told she could not go in resident #2's room alone. The CNA told her resident #2 had to tell the staff member to leave when the CNA was going to give him a bed bath. The staff member would not leave and required the hospice CNA give the bed bath with the staff member in the room. Review of resident #2's EMR showed a General Note, dated 9/4/24 at 5:25 p.m., Accompanied Hospice Aide while she visited with resident. Resident was pleasant, brief was dry, no complaints of pain or discomfort. Resident refused bath but did agree to let hospice aide give him a bed bath. Review of resident #2's EMR showed a General Note on 9/4/24 at 9:30 a.m., Accompanied Hospice nurse while she visited with resident. Resident was pleasant, brief was dry, no complaints of pain or discomfort. Resident did complain about difficulty sleeping at night. During an interview on 9/18/24 at 12:15 p.m., staff member D said she was instructed by staff member E to accompany any of the hospice personnel to resident #2's room. She was told by staff member E the hospice personnel were putting ideas in resident #2's head, and that they should not be left alone in the room with resident #2. Staff D said that way facility staff could hear what was being said and report back to staff member E. Staff member D said staff member E told her to document resident #2's room was clean, and his brief was dry, and he did not have any complaints because the hospice personnel were making false claims. Staff member D said staff member E told her what to document. Staff member D said documentation was not the same for other residents on hospice. She said she would not typically even document when hospice came to see a resident because they do their own documentation in the hospice records. She said the only reason she documented like that for resident #2 was because staff member E instructed her exactly what to chart. Staff member D said staff member E told her to stay with the hospice personnel while they were with resident #2. Two requests (on 9/18/24 at 12:30 p.m. and on 9/19/24 at 11:45 a.m.) were made to staff member A to interview staff member E. Staff member E was not made available for an interview by the end of the survey. Review of a facility document titled, Exhibit B Resident Rights, not dated, showed: Each resident shall have the right: . (continued on next page)

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) to privacy in treatment and personal care: . e) to privately talk and/or meet with and see anyone; .

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on observation and interview the facility failed to provide a clean homelike environment for 3 (#s 2, 3, and 4) of 3 sampled residents and had the potential to affect all residents who go to the dining room. Findings include: During an observation and interview on [DATE] at 3:22 p.m., resident #2 was observed in his room on his bed wearing an incontinence brief. The brief was torn off on one side exposing the residents left hip and half of his left glute. Resident #2 was not covered with a sheet or a blanket and was not wearing any clothing. There were two urinals in his garbage can. One of the urinals was full to the handle with dark amber urine. The other was full above the handle with clear yellow urine. The room smelled of stale urine. There was a sticky material on the floor. Resident #2 said the staff would come to empty the urinals if he used his call light to ask. He said occasionally the staff would empty the urinals without being told but usually not. Resident #2 said he would wear clothing if he had any that fit properly but he had not had any clothing that was comfortable since he was admitted to the facility. He stated the floor was dirty often but said the staff were busy, so he did not complain about it. There were two flies in the resident's room landing on his bedside table and crawling on his cup. During a telephone interview on [DATE] at 8:46 a.m., NF2 said the room was usually dirty when she came in to see resident #2. She said his urinals were usually full sitting in his garbage can. She described coming in to see resident #2 and finding him completely naked on his bed uncovered. She said resident #2 had taken his brief off and put it in his wash basin because it was soiled with urine. NF2 stated resident #2 had told her his skin was getting itchy, so he took the brief off. During an observation and interview on [DATE] at 10:25 a.m., the two urinals were full again in resident #2's garbage can. The linens on the bed were the same as observed prior (on [DATE] at 3:22 p.m.). There were several flies in resident #2's room. NF3 said resident #2's room was typically filthy when she arrived to care for resident #2. Resident #2 was wearing sweatpants. Resident #2 said this was the first time he had pants in a year. He said one of the staff members got them from the laundry and resident #2 said, I think they took them from some guy that died in here. Resident #2 said the sweatpants did not fit him properly. He pulled the waistband out away from his abdomen, and the waistband allowed a gap of approximately 3 inches. During an interview on [DATE] at 12:15 p.m., staff member D said she was assigned to resident #2. When she was asked about the urinals in resident #2's garbage can, she said she had not noticed the urinals, but she said it had been a busy day. She said she would have the CNA empty them. She said the CNAs were supposed to do regular rounds and check on the resident's needs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 4:30 p.m., residents #3 and #4 were in the hallway. Resident #4 had a fly swatter and was hitting a fly in the hallway. Resident #4 stated he had the fly swatter because there were so many flies in the dining room it was disgusting. Resident #3 agreed, he said the flies in the building were terrible. As resident #3 was talking, a fly landed on the wall. Resident #4 hit it with his fly swatter and then rolled over the fly with his wheelchair. Resident #4 said the flies in the dining area were landing on his food and they were on the tables and walls. Another fly landed on the wall next to resident #3 and resident #4 hit that fly with his fly swatter, killing it, then it landed on the floor in the hallway.

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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. 44770 Based on interview and record review, the facility failed to meet professional standards for medications being administered, per the physician's order, and the resident had insomnia, for 1(#2) of 1 sampled resident. Findings include: During an interview on 9/18/24 at 8:46 a.m., NF2 said she faxed an order for Clonazepam (8/29/24) written by NF1 for resident #2. Resident #2 told NF2 he was not sleeping well and would like to have his Clonazepam started again. NF2 said she spoke with NF1, and he ordered the Clonazepam as resident #2 requested. NF2 said when the facility received the physician order, staff member E faxed it back with a handwritten note, requesting clarification. NF2 said she spoke to staff member E and explained NF1 wanted resident #2 to begin taking the Clonazepam. NF2 said she explained to staff member E they were aware the psychologist discontinued it (the medication), and they wanted to put him back on it (on 8/30/24). During an interview on 9/17/24 at 3:22 p.m., resident #2 stated he never wanted staff member C to be his physician and had told her on several occasions he did not want to see her. He said NF1 was his primary care physician, and staff member C kept taking away the medications NF1 ordered for him. He said he had been having a hard time sleeping and had been having severe anxiety, but staff member C would not allow the nurses to give him the medication NF1 ordered for him to help with his sleep and anxiety. Review of resident #2's EMR showed an order from NF1, dated 8/29/24 at 9:14 a.m. for Clonazepam 0.5 mg 1 tablet a day for anxiety/agitation and insomnia. A nurse note, dated 8/30/24 at 4:51 p.m., authored by staff member E, showed, received call from [NF2 Name] for order clarification from [NF1 Name]. [NF2 name] stated order is part of comfort (care) package. Resident has no s/s of actively dying including but not limited to: no death rattle, no skin discoloration, no SOB, resident alert and orientated, comfortable at this time. Sent to MD to review. [sic] Resident #2's MAR lacked an order entered for Clonazepam 0.5 mg 1 tablet daily for anxiety/agitation and insomnia. During a telephone interview on 9/19/24 at 11:51 a.m., NF2 stated she spoke to staff member E and told her NF1 intended for resident #2 to receive the Clonazepam per the physician order. She said she told staff member E it was ordered as part of his regular comfort care package, but she did not tell staff member E it was only to be used when the resident was actively dying. She said resident #2 was on hospice services, NF1 ordered the medication for resident #2, and NF1 intended for resident #2 to receive the medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 9/19/24 at 12:56 p.m., NF1 said he was not aware the facility was not giving resident #2 the Clonazepam he ordered. He said his nurse clarified with the facility and he was aware the psychologist discontinued it, but he ordered it again because the resident was having a hard time sleeping and had been suffering from insomnia. NF1 said he could not understand why staff member C kept trying to decrease the medications he ordered for resident #2. He said he spoke to her a few times trying to coordinate care for resident #2. NF1 stated, I feel like they need to have more compassion for this guy. I have no idea why she (staff member C) is so adamant about these things (decreasing resident #2's hospice medications). We really should be able to make this work together. The best solution would be to get him (resident #2) back in the VA in Butte where he can have his regular physicians and VA care. During an interview on 9/18/24 at 1:50 p.m., staff member C said she typically would not change medications ordered by a hospice physician. She stated in a typical situation she would only manage medications related to a resident's other medical diagnoses like diabetes or congestive heart failure. She said the hospice physician should take care of all the other end of life care medications. She said she does not like residents to be prescribed opioid medication and benzodiazepines but that there were times when those orders were necessary. She asked NF1 about the medications, and NF1 said he did not want to change the medications and felt resident #2 needed them. After speaking with NF1, staff member C stated she was concerned about resident #2 taking benzodiazepines and opioids at the same time and decided to send the medication list to the pharmacist for medication review. Staff member C said she decided to send the medication list for resident #2 to a pharmacist to see if the pharmacist agreed with her. She also referred resident #2 to see a psychologist. The psychologist discontinued Clonazepam and Lorazepam for resident #2. Staff member C was aware NF1 had reordered the Clonazepam for resident #2 on 8/29/24, but she had the facility send it back to him for clarification and staff member C said the resident was not receiving the Clonazepam. She stated, We are just going to sit on that order for now. She stated the facility was awaiting clarification from NF1. She said she had not contacted NF1 to ask about the order and she was aware the order had been written on 8/29/24 (19 days prior). She was not aware of the note written by staff member E indicating NF1 clarified the order. Staff member C said she could not remember if she had spoken to staff member E after the order was clarified on 8/30/24. Two requests (on 9/18/24 at 12:30 p.m. and on 9/19/24 at 11:45 a.m.) were made to staff member A to interview staff member E. Staff member E was not made available for an interview by the end of the survey. Review of General Notes, in the resident's EHR, for resident #2, written from 4/22/24 through 9/18/24, lacked documentation of resident #2 having signs or symptoms of oversedation. General Notes written on 4/22/24 showed resident #2 complained of insomnia, on 9/7/24 the notes showed resident slept poorly, 9/16/24 resident slept poorly, and on 9/17/24 resident #2 was awake all night.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 44770 Based on observation, interview, and record review the facility failed to provide hospice services in coordination with the management and staff of the nursing home per the hospice agreement for 1 (#2) of 2 sampled residents. Findings include: During a telephone interview on 9/18/24 at 8:46 a.m., NF2 said she and another nurse saw resident #2 once a week for hospice services. She said the facility had not had a group care meeting in months. She said staff member C had been going against NF1's orders and not providing medications ordered by NF1. NF2 said resident #2's room was usually dirty and his urinals were usually full sitting in his garbage can when she came in to see resident #2. She said resident #2 had been requesting to have a different physician from staff member C, but the facility was not allowing him to change physicians. NF2 said the facility was not allowing her or any of the other hospice staff to visit resident #2 without being escorted by one of the facility staff members. NF2 said she did not know why staff member C was going around NF1's orders. NF2 said she was concerned because of the discord between staff member C and NF1 was affecting resident #2's care. NF2 stated resident #2 was not receiving the medications that had been ordered by NF1. During an interview and observation on 9/18/24 at 10:25 a.m., resident #2 was sitting on his bed. NF3 was in the room with resident #2 providing cares. Resident #2's garbage can contained two full urinals. NF3 said she comes to see resident #2 weekly along with another nurse from hospice. She said his room was usually dirty and the urinals were usually full in the garbage can. She said the facility had not been allowing the hospice staff to visit resident #2 without having a facility staff member accompany them. When she arrived for this visit no facility staff noticed her, so she went quickly down the hall, so they wouldn't send anyone with her. Resident #2 said he did not like it when he wasn't allowed to visit with the hospice nurses alone. He said he did not like it when the facility staff listened to his conversations with the hospice staff. Resident #2 said he did not want to see staff member C at all, but she had told him he did not have a choice because he couldn't fight with the VA. He said he liked NF1 and the other provider from hospice, and he didn't know why he also had to see staff member C. NF3 said staff member C would not give resident #2 the medication ordered by NF1. NF3 said the facility was saying resident #2 was sleeping all the time and showing signs of being over sedated so they were trying to go against NF1's orders. NF3 said resident #2 had not been over sedated any time she came to see him and that resident #2 had been complaining of not being able to sleep and his anxiety had been out of control. Resident #2 said he had been having a hard time sleeping, and he had been having anxiety. NF3 said staff members C and E had been undermining what the hospice providers had been trying to do for resident #2. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/24 at 1:50 p.m. staff member C said typically the hospice physician would take care of medication orders for residents who were on hospice care. She stated she might write orders for residents who had been on hospice for a long time and who required medication for diagnoses such as diabetes or congestive heart failure. She said she did not like having a resident on opioids and benzodiazepines at the same time and she talked to NF1 about resident #2. She said NF1 told her he wanted to continue those medications for resident #2's hospice care so she sent resident #2's list of medications to a pharmacist to see if the pharmacist would recommend decreasing the medications and she also had resident #2 see a psychologist. She said the psychologist agreed with her and discontinued the medications (Lorazepam and Clonazepam). During an interview on 9/19/24 at 12:56 p.m., NF1 said he did not know why staff member C was trying to change his orders for resident #2's hospice care. He said typically the hospice provider would write the medication orders for hospice residents and the primary physician would only manage the regular medications for a resident. He said he spoke to staff member C a few times trying to coordinate care for resident #2. NF1 stated, I feel like they need to have more compassion for this guy. I have no idea why she (staff member C) is so adamant about these things (decreasing resident #2's hospice medications). We really should be able to make this work together. The best solution would be to get him (resident #2) back in the VA in Butte where he can have his regular physicians and VA care. Review of a facility provided document titled, Hospice-Skilled Nursing Facility Agreement, dated 5/13/22, showed, an agreement between the facility and the hospice agency taking care of resident #2. The agreement showed, .All services provided by Nursing Home hereunder shall be (i) authorized by Hospice, (ii) furnished in a safe and effective manner by qualified personnel and (iii) delivered in accordance with the Hospice Patient's Hospice Plan of Care. Hospice shall be responsible for determining the appropriate course of hospice care . Nursing Home shall provide Nursing Home Room and Board Services . including personal care services, including assistance in activities, administration of medications, maintaining cleanliness of a resident's room .