| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275134 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/25/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ivy at Deer Lodge | 1100 Texas Ave<br>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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32998<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were free of neglect for 3 (#s 2, 3, and 4) of 6 sampled residents. The facility failed to have systems in place for wound care, which resulted in three Immediate Jeopardy deficiencies being identified. Resident outcomes included:<br><br>a. Resident #2 showed progressive worsening of pressure ulcers from a Stage II (blisters) worsening to Unstageable in ten days, and the resident was admitted to the hospital for the worsening wounds with foul odor, increased assistance with ADLs, and edema.<br><br>b. Resident #3 showed progressive worsening of pressure ulcers and was placed on hospice, following a hospital stay with sepsis, and passed away at the facility, upon returning.<br><br>c. Resident #4 was admitted to the facility with skin tears, with varying stages of healing, and pressure injuries. Resident #4's wounds showed worsening over time, progressing from skin tears to wound injuries. Resident #4 was transferred to the hospital on 11/9/24, and passed away on 11/10/24 at the hospital, due to sepsis (infection).<br><br>On 11/20/24, three Immediate Jeopardy's were announced to the Administrator and Director of Nursing, one specifically identified as neglect of care, stemming from the following deficiencies identified:<br><br>a. Pressure Ulcers, and the failure to identify, assess, document, measure, to obtain and follow physician orders for wound care, and the facility failed to develop a wound management system that was sufficient to meet the resident needs for wound care.<br><br>The Severity and Scope of the Immediate Jeopardy for the Neglect of Care was identified to be at the level of K, and lowered to an H when the immediacy was removed for the residents.<br><br>b. Pain Management and Neglect was cited at the Immediate Jeopardy level for the failure to assess, document, treat, and provide necessary pain management in a timely manner, and prior to wound care, and this failure resulted in moderate to severe pain during wound care, and refusals of wound care, for 1 (#4). The facility failed to identify changes in a resident's condition, and treat the change(s) as needed, and failed to do a root cause analysis to determine the causes of resident pain related to wounds in an attempt to alleviate or decrease the pain.<br><br>(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: 275134 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/25/2024 |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Severity and Scope of the Pain Management and Neglect Immediate Jeopardy's were cited at the level of J, and lowered to a G, upon the removal of the immediacy for the residents involved. Acceptable Plans for the removal of immediacy were received, and approved by the State Survey Agency, as of 11/25/24 at 5:16 p.m.<br><br>Findings include:<br><br>1. During an interview on 11/18/24 at 3:56 p.m., NF1 said she was contacted on 11/10/24, and told resident #4 had passed away, within 24 hours of being admitted to the hospital. She then contacted a 3rd party to perform an autopsy due to the physician report. NF1 said the physician reported, It was the worst case of neglect they have ever seen. NF1 said, His wounds were horrific, and he basically had no backside, his arms and feet were involved. The resident's official Cause of Death was severe sepsis.<br><br>During an interview on 11/20/24 at 9:49 a.m., staff member F said she was working the day resident #4 was admitted to the facility. When resident #4 arrived at the facility, he refused to move himself from the stretcher to the bed. Staff member F said he was in extreme pain. Resident #4 was transferred by staff from the stretcher to the bed. Staff member F said the facility was aware resident #4 had severe wounds when the facility agreed to admit him. Staff member F said, He basically had no skin on the back of his legs, his pannus, and his back. Staff member F said resident #4 had so many wounds over his body, she had to ask for help to do his admission skin evaluation. Staff member F said resident #4 was in a lot of pain while being admitted to the facility and staff member F felt he refused care due to his pain.<br><br>During an interview on 11/20/24 at 3:28 p.m., staff member B said resident #4 would refuse cares and pain medications. His wounds were all superficial, and they would bleed. Staff member B said, one weekend he refused all cares and medications; than he began to decline. Staff member B said the resident was in pain, and the facility sent him to the emergency department for an evaluation, and he was admitted to the hospital.<br><br>During an interview on 11/21/24 at 9:35 a.m., staff member E said she was concerned about resident #4's pain and pain control. Resident #4 complained of pain a lot, and he did not want to participate in therapy or other activities, and he would not participate in a lot in his care. Staff member E said she contacted staff member D, and she came in to talk with resident #4. Staff member E said after the resident was there for a week, the facility started working to adjust the resident's pain medications. Staff member E said resident #4 had a pain patch, which was not given for the treatment of wounds, and only wanted Tylenol for his pain. She asked him why he only wanted Tylenol, and he said it was because the Norco was not effective for his pain. Staff member E said he had as needed pain medication ordered, but he was not on a routine pain medication regimen (specifically for wounds or care of them).<br><br>During an interview on 11/20/24 at 9:29 a.m., staff member F stated resident #4 was admitted , and he had no skin on his buttock, back, and arms. Staff member F stated resident #4 refused to get off the gurney when he first arrived, due to the pain. Staff member F stated the resident was in so much pain he would refuse cares and dressing changes for his wounds.<br><br>(continued on next page) |

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| | 275134 | A. Building<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 11/20/24 at 2:35 p.m., staff member D stated resident #4 had multiple wounds, which were caused by shearing (pressure and friction injuring the skin at the same time). Staff member D stated the resident had declined in the two days prior to being transferred to the hospital, and the wounds were infected toward the weekend, and it was difficult to get him out of bed, and to turn and reposition the resident. Staff member D stated changes were made to the resident's pain regimen. Staff member D said resident #4's wounds were primarily sheering wounds on his buttocks, on his legs, and one under his pannus. The wounds were not a pressure wound, and there was never any discharge (drainage). Resident #4's wounds would bleed, but were not infected. Staff member D said resident #4 was on a patch (pain patch for his chronic back pain), and he received hydrocodone for pain control when he arrived. The resident only wanted to take Tylenol for his pain. The facility kept resident #4 on that pain regimen. Staff member D said resident #4 refused all treatments and medications over a weekend, and when she evaluated him on the following Monday, she discontinued the hydrocodone and started him on oxycodone. He remained on the Tylenol and pain patch. Staff member D said the facility could not get resident #4 to participate in therapies or get out of bed. Staff member D said resident #4's wounds were not infected when he was sent to the emergency department for an evaluation.<br><br>Record review of resident #4's order summary report, dated 10/1/24 through 11/9/24, showed an order for resident #4 for turning and repositioning as appropriate. Dressing changes were ordered as needed for wound care for 14 days. The physician order did not show a specific time frame for turning and repositioning of the resident for wound prevention, and the nursing staff neglected to consistently document resident #4's response or refusals for repositioning. The licensed staff neglected to ensure the wound care orders were in place, comprehensive, and that staff had necessary knowledge to ensure the resident was repositioned in a manner that would help prevent further decline or deterioration of the wounds, nor did they include necessary details for the changing of dressings and treatment of resident #4's wounds.<br><br>Review of resident #4's electronic medical record showed:<br><br>-10/3/24 Resident #4 admission assessment showed a left hip Stage II pressure ulcer 14.0 cm x 5.5 cm; right buttock Stage II pressure ulcer 2.5 cm x 1.5 cm; right buttock Stage II pressure ulcer 2.5 cm x 2.8 cm; right buttock pressure ulcer Stage II 2.5 cm x 3 cm: left buttock Stage II pressure ulcer 2.5 cm x 3 cm; left forearm skin tear 5.8 cm x 3.2 cm; multiple left thigh and multiple abdominal wounds. The facility neglected to document resident #4's left scapula pressure ulcer, present on admission from the transferring facility. Resident #4 was unable to turn and reposition himself independently and was documented to have a pain rating of 5 out of 10, with 10 being the worst level of pain.<br><br>-10/4/24 Resident #4's progress note, documented at 00:27 a.m., showed the resident was experiencing pain due to several wounds on his back. No pain level or interventions for pain were documented.<br><br>-10/8/24 Resident #4's progress note at 4:26 a.m., showed attempts to reposition the resident were refused due to his severe pain. No pain level or interventions for pain were documented. His next pain medication was given at 6:00 a.m.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -10/16/24 Resident #4 was unable to turn and reposition himself independently. All of his skin wounds, including pressure wounds, were identified as skin tears. Nursing staff neglected to document the correct wound classifications, measurements and assessment for resident #4's pressure wounds, which directs the type of wound treatments provided.<br><br>-10/17/24 Resident #4's progress note at 12:27 a.m., showed the resident refused to be repositioned. No documentation was provided for why he had refused. Previous pain medication was given at 6:00 a.m.<br><br>-10/23/24 Resident #4's progress note at 8:09 p.m., showed resident #4 refused incontinent care, his previous medication for pain was given at 2:00 p.m. No documentation was provided for why he had refused. Resident #4's skin observation showed he had limited mobility, bowel and bladder incontinence with dry skin and itching. Documentation showed he had a potential for skin infection and was a nutritional risk. Two of resident #4's wounds were listed as Stage II pressure injuries and four wounds were listed as abrasions. The nursing staff neglected to document wound measurements or the status of all his wounds. There was no documentation on resident #4's ability to turn and reposition independently.<br><br>-10/25/24 Resident #4's skin/wound assessment showed resident #4 refused to be repositioned off of his back. However, documentation showed the following for resident #4's bilateral right buttock Stage II pressure ulcer 5.0 cm x 4.4 cm x 0.1 cm; left buttock Stage II pressure ulcer 2.5 cm x 3.0 cm x .01 cm; there were multiple small wounds at various stages of healing on/around the anus; the left forearm healed; left knee healed; medial shin healed; right thigh x 2 - 2.5 cm x 2.5 cm; posterior shin/calf 7.5 cm x 3.5 cm, partial thickness with loss of dermis, wound bed shallow, with large amount of serosanguineous drainage on buttocks, no odor. Nursing staff neglected to document on his left scapula wound.<br><br>-10/27/24 Resident #4's progress note at 1:13 p.m. showed resident #4 refused to be repositioned, his previous pain medication was given at 6:00 am. No documentation was provided for why he refused repositioning.<br><br>-10/30/24 Resident #4 had limited mobility, bowel and bladder incontinence with dry skin and itching. Documentation showed he had a potential for skin infection, was at nutritional risk, and at risk for fluid and hydration concern. Two of resident #4's wounds were listed as pressure injuries, and six of his wounds were listed as abrasions or skin tears. The nursing staff neglected to document wound staging (severity/type), wound measurements or the status of all wounds.<br><br>-10/31/24 Resident #4's progress note showed the CNA notified the nurse that resident #4 had redness to his heel. Nursing assessed his heel, and the resident had been resting against the footboard of the bed. A new blister was identified on his heel. Nursing staff neglected to document which heel was involved and include measurements or necessary details of the wound.<br><br>-11/2/24 Resident #4's progress note at 4:07 p.m. showed the resident declined any turning, repositioning, or skin checks, stating, I am not having a good day. No documentation was found on his pain level or why he was not having a good day.<br><br>-11/3/24 Resident #4's progress note at 1:13 p.m., showed resident #4 continued to refuse all cares and dressing changes. The last dose of pain medication was given at 6:00 a.m.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -11/4/24 Resident #4's progress note at 2:47 a.m. showed resident #4 allowed staff to perform peri care. The resident began to refuse further care because it hurt too much (due to wounds). The resident refused all care and asked to be left alone and let the pain pill work.<br><br>-11/9/24 Resident #4's progress note showed he had developed a new sheer area to the back of his left shoulder. Pressure ulcers were not healing, and the resident was sent to the ER for further evaluation.<br><br>Record review of resident #4's electronic medical record showed there were five days without wound care orders, from 10/17/24 to 10/22/24, and two days without wound orders, from 10/23/24 to 10/25/24. All wounds were left open to air, and there were no orders for the different types of wounds, allowing for bacteria to enter the wounds if not treated appropriately.<br><br>Resident #4's medical record showed nursing staff neglected to comprehensively and consistently assess, document, and treat the resident with necessary interventions based on the type and severity of the wounds resident #4 had. The resident's pain was not treated prior to the dressing changes, which caused refusals of care, leading to the worsening of wounds. Resident #4 was not on routine pain medications to account for the pain he was experiencing due to his wounds.<br><br>2. During an observation and interview on 11/20/24 at 9:49 a.m., resident #2 was observed to be in her room and reclined on her bed. Resident #2 had both heels resting on the bed surface, no padding or offloading of her heels were observed. The room had a strong foul odor upon entering from the hallway. Staff member F donned gloves and removed the dressings from both of the resident's feet. The right heel wound was cleaned, and a small amount of tissue was debrided from around the wound. The right heel wound was dry, measured 9.5 cm x 4.5 cm, and had a foul odor. The left heel wound was dry, measured 12 cm x 4.5 cm, and had a foul odor. Staff member F cleaned the wounds with saline, applied betadine with a swab, and wrapped both feet with kerlix gauze. Staff member F said she does not measure the wounds with each dressing change but will measure them weekly when she does a big evaluation. She does not stage (assess severity) the wounds because it is beyond her scope of practice. Staff member F said the treatment order was for a dressing change daily, and she will document the dressing change was performed in the nursing note. Resident #2 stated she acquired the wound in the facility, from the bed. She stated she walked into the facility for rehab and now she is in a wheelchair. The resident was no longer able to walk or stand on her feet. Staff member F then corrected resident #2 stating; she acquired the wounds while in the hospital. Resident #2 was observed shaking her head from side to side in disagreement. Staff member F said resident #2 had just finished antibiotics for her heel wounds.<br><br>During an interview on 11/20/24 at 2:35 p.m., staff member D said resident #2 had heel wounds because she refuses to offload her heels. Staff member D said resident #2 has had an odor from her wounds for quite a few weeks, and the wound clinic did not recommend any antibiotics, and the wound clinic will not debride her wounds until she sees a vascular surgeon for evaluation. Staff member D said the antibiotics the resident was given was for a urinary tract infection, not for her wounds.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 11/21/24 at 12:21 p.m., resident #2 said she was admitted to the facility for rehabilitation and strengthening. She was receiving physical therapy services and was getting stronger. Resident #2 said the facility then fired the physical therapist, and she did not receive therapy services for several weeks, until a new physical therapist was hired. She spent that time sitting in a chair or lying in bed, causing her to develop pressure wounds on her heels. Resident #2 said when she was admitted to the hospital for her kidney failure, her wounds would be debrided. Resident #2 said she is no longer able to walk because of the wounds on her heels.<br><br>During an interview on 11/25/24 at 3:49 p.m., staff member B stated resident #2 was found to have a non-trauma related fracture to her foot, due to deterioration of her bones. There was a concern with the aeration of the tissue in her foot. Resident #2 requested to be transported to the facility near her, for wound care.<br><br>Review of resident #2's electronic medical record showed:<br><br>-8/2/24- Resident #2's admission assessment showed a vascular wound on her 3rd toe, right foot. No measurements were documented.<br><br>-8/16/24 Resident #2's skin observation showed a left toe wound marked as other. Nursing neglected to document the type of wound or measurements of the wound.<br><br>-8/23/24 Resident #2's skin observation showed a vascular wound on her 2nd toe, right foot. Nursing neglected to document the type of wound or measurements of the wound.<br><br>-8/30/24 Resident #2's skin observation showed an abrasion to the right knee, 2 cm x 1 cm; right toe 2 cm x 1 cm. Nursing neglected to document the location or a description of the toe wounds.<br><br>-9/2/24 Resident #2's skin/wound note showed a right foot 3rd digit measuring 1 cm x 1 cm; left foot 2nd digit measuring 0.3 cm x 0.3 cm.<br><br>-9/8/24 Resident #2's skin/wound note showed a right 3rd digit wound measuring 0.5 cm x 0.5 cm; left 2nd digit measuring 0.2 cm x 0.2 cm; blister to the right heel 4.0 cm x 2.4 cm.<br><br>-9/14/24 Resident #2's skin/wound note showed a right 3rd digit wound measuring 1.5 cm x 0.3 cm x 0.4 cm; left 2nd digit measuring 0.5 cm x 1.0 cm; nursing neglected to document the heel wound.<br><br>-9/28/24 Resident #2's skin/wound note showed a right heel 0.8 cm x 0.5 cm eschar present, Unstageable; left heel 2.7 cm x 1.5 cm eschar present, Unstageable. The wounds were now documented as hospital acquired pressure wounds to bilateral feet and there was no further documentation within the medical record for the right 3rd digit or left 2nd digit wounds.<br><br>-10/6/24 Resident #2's skin/wound notes showed a right heel measuring 0.7 cm x 0.6 cm eschar present; Left heel measuring 2.5 cm x 1.3 cm eschar present.<br><br>-10/17/24 Resident #2's skin/wound notes showed a right heel measuring 0.7 cm x 0.6 cm; left heel measuring 2.8 cm x 1.8 cm.<br><br>(continued on next page) |

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

-10/25/24 Resident #2's skin/wound notes showed a right heel measuring 0.7 cm x 0.6 cm; left heel measuring 3.0 cm x 3.0 cm.

-10/28/24 Resident #2's skin/wound notes showed the left heel wound was now measuring 8.5 cm x 4 cm with a continued foul odor and moderate drainage. Resident #2 was on antibiotics for treatment. The left heel wound had grown (deteriorated) significantly in three days.

-11/1/24 Resident #2's skin/wound notes showed the right heel measuring 5.8 cm x 5.5 cm, eschar present; left heel measuring 9 cm x 4.5 cm, eschar present with no odor.

-11/6/24 Resident #2's skin/wound notes showed the right heel measuring 11.4 cm x 6.3 cm; left heel measuring 11.8 cm x 4.9 cm. Both heel wounds had increased in size significantly in five days.

A review of the wound documentation showed the facility neglected to consistently document the wound measurements and type of wound with staging, and the condition of the wounds. Resident #2's skin assessments were not consistently accurate for the number of wounds, location of the wounds, or the types of the wounds. These failures contributed to the worsening of the wounds over time.

Review of resident #2's Care Plan showed bilateral pressure injuries to the left heel and right posterior foot, with a wound infection. Interventions were antibiotic therapy, monitor for new or worsening symptoms, enhanced barrier precautions due to wounds, and a referral to the wound clinic.

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3. During an interview on 11/20/24 at 9:49 a.m., staff member F said resident #3 was able to walk prior to his hip fracture. Staff member F said resident #3 was noted to have a small area on his heel that looked like a sheer injury. The following week, the area had increased in size and eventually required surgical debridement.

During an interview on 11/21/24 at 9:35 a.m., staff member E said she cared for resident #3 often, as she was usually assigned the hallway, where his room was located. Staff member E said resident #3 had facility acquired pressure ulcers. Staff member E said resident #3 would motor around in a wheelchair after his hip fracture and was quite social. Staff member E said resident #3 declined very quickly after the pressure ulcers were acquired and identified, and she felt he did not want to go on and just gave up.

Review of resident #3's EMR documentation, showed:

8/7/24 - Weekly skin assessment showed a popped blister, on the left heel, measuring 3.2 cm x 7.2 cm. There was no description of the wound or drainage noted.

8/14/24 - Weekly skin assessment showed a right buttock pressure wound measuring 3 cm x 2.2 cm x 0.1 cm, Stage II, and a left heel deep tissue wound measuring 4 cm x 5.2 cm x 0.1 cm. No wound assessment or drainage was noted.

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 8/16/24 - Skin/wound note showed, a deep tissue injury to the resident's left heel, and a pressure ulcer to the right buttock. Left heel measuring 2.7 cm x 5 cm. Skin around the wound is intact and healthy. Pressure ulcer to right buttock 1.5 cm x 1.8 cm x .01 cm. Wound bed slough, light serous drainage, no odor. Skin around wound was reddened.<br><br>8/18/24 - Skin/wound note showed, pressure ulcer on right buttock was cleansed, and a border dressing was applied. The wound had slough, light serous drainage, and an odor was present. No documentation was provided for the physician notification. A change in size, depth, or surrounding tissue was not documented. No documentation for the left heel wound was found.<br><br>8/19/24 - Skin/wound note showed, pressure ulcer on right buttock was cleansed, and a border dressing was applied. The wound had slough, light serous drainage, and an odor was present. No documentation was provided for the physician notification. A change in the size, depth, or surrounding tissue was not documented for the wound, and there was no documentation for left heel wound found.<br><br>8/21/24 - Weekly skin assessment showed a right buttock pressure wound 3.5 cm x 5 cm x 0.2 cm, Stage II, and a left heel deep tissue injury measured 5.25 cm x 6.25 cm x 0.1 cm. No wound assessment or drainage was noted.<br><br>8/28/24 - A general progress note for the resident showed a dressing change was made to the right buttock per the physician orders. Eschar was covering the wound bed, no scant drainage, no odor, and no signs or symptoms of infection were noted. No documentation for the left heel wound was found. The weekly skin assessment showed a right buttock pressure wound and a left deep tissue wound with no measurements for either wound.<br><br>8/31/24 - The resident's Skin/wound note showed, a certified wound clinician assessed the resident's wound. New treatment orders were received for a deep tissue injury to the resident's left heel measuring 4 cm x 4 cm, eschar was on the wound bed, foul odor, no drainage was noted, and wound edges were clean and intact. A pressure ulcer to the right buttock measuring 5 cm x 3 cm x 5 cm, with eschar was on the wound bed, light serous drainage, edges were undefined, no odor was present. The skin around the wound was healthy. A referral to the wound clinic for a consult was made.<br><br>9/5/24 - Resident #3 was transferred to the emergency department for an evaluation due to an altered mental status. He was admitted to the facility with a diagnosis of acute osteomyelitis of the left ankle and foot, related to his left heel wound.<br><br>9/24/24- The resident returned to the facility, from hospitalization . The Weekly skin assessment showed a coccyx wound measuring 1 cm x 0.4 cm, a right buttock pressure wound that measured 6 cm x 8.5 cm x 1.8 cm, and a left heel pressure wound that measured 4.2 cm x 2.6 cm x 0.5 cm. No documentation of a wound assessment or drainage was noted.<br><br>9/28/24 - the Skin/wound note showed, the right buttock wound measured 6 cm x 8.5 cm x 1.8 cm, had 100% granulation, the wound edges were defined, and there was sanguineous drainage with no odor. The left heel wound measured 4.2 cm x 2.6 cm x 0.5 cm, 100% granulation, the wound edges were defined, and there was sanguineous drainage with no odor. The resident was followed by the wound clinic for evaluation and treatment. The note showed, . resident #3's wounds are related to a hospital acquired Stage IV pressure ulcer to the right buttock and left heel with surgical debridement.<br><br>(continued on next page) |

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

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 10/1/24 - The weekly skin assessment showed a right buttock pressure wound, and a left heel wound. There was no documentation of a coccyx wound, no documentation of wound assessments, and no documentation to show if drainage was noted.<br><br>10/6/24 - A general progress note showed, while changing the wound vac on the resident's buttock, nursing noted a red and open area on resident #3's coccyx. The area was cleaned with normal saline, and a Tegaderm was applied until the area could be assessed for treatment by the IDT team. The ADON and provider were notified. No measurements of either the coccyx or right heel were documented. No IDT notes were provided that addressed any treatment or assessment of the coccyx wound.<br><br>10/8/24- A general progress note showed, the newest wound on resident #3's coccyx appeared unchanged. No description of the wound or wound measurements were documented.<br><br>10/11/24 - The weekly skin check showed a right buttock pressure wound, a left heel pressure wound, both Stage IV, and a sacrum pressure wound, Stage II. No wound measurements were documented, and there were no wound assessments or drainage noted.<br><br>10/12/24 - The weekly skin assessment showed a right buttock pressure wound and a left heel wound, both [NAME] IV, with no measurements documented. No documentation was present on the coccyx wound, no documentation was present of the wound assessments or drainage.<br><br>10/17/24 - The Skin/wound note showed, resident #3's right buttock ischium wound measured 6 cm x 8.3 cm x 2.9 cm with 50% slough and less than 50% bone, is superficial, wound edges defined. The wound had sanguineous drainage with no odor, and surrounding tissue discoloration. The coccyx had non blanchable reddened area with measurements of 2 cm x 2.5 cm x 0.1 cm, Stage III wound. There was a small amount of serosanguineous drainage, no odor was present, 75% slough, 25% granulation, no odor, and discoloration of surrounding tissue. The left heel wound measured 4 cm x 5.9 cm x 0.3 cm with 0.2 cm undermining, 50% yellow slough and 50% exposed bone. The wound edges were defined, there was serosanguineous drainage with no odor, and the tissue surrounding the wound was healthy and pink.<br><br>10/18/24 - The weekly skin assessment showed a left buttock surgical incision, and a left heel surgical incision. No measurements or assessments were documented and the coccyx wound was not documented.<br><br>10/25/24 - The Skin/wound note showed, resident #3's right buttock ischium wound measured 6.7 cm x 6.2 cm x 3.5 cm, with undermining of 2.7 cm, 50% slough, less than 50% bone is superficial, wound edges were defined, sanguineous drainage with no odor, and surrounding tissue discoloration. The coccyx had a non-blanchable reddened area with measurements of 3.1 cm x 2.5 cm x 0.1 cm, Stage III wound with a small amount of serosanguineous drainage, no odor and slough 75%, 25% granulation, and discoloration of surrounding tissue. No documentation of the left heel wound was found.<br><br>10/29/24 - Resident #3 was admitted to hospice services.<br><br>11/4/24- Resident #3 became nonresponsive and passed away at the facility.<br><br>(continued on next page) |

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| Ivy at Deer Lodge | 1100 Texas Ave<br>Deer Lodge, MT 59722 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of a facility provided, Provider Visit Note, dated 9/30/24 by staff member D, showed a full readmission evaluation. The section for the resident's extremities/integumentary evaluation showed bilateral lower extremity weakness, with resident #3 using a wheelchair for mobility, and a wound vac in place on the sacrum and left heel. The note referred to the registered nurses's note for details on the resident's wounds. No further wound documentation was noted.<br><br>Record review of facility provided, Provider Visit Note, dated 10/22/24 by staff member D, showed a 30-day medical compliance visit. The section for extremities/integumentary evaluation, showed 2+ bilateral lower extremity edema and left upper extremity edema and the wound vac was in place on the sacrum and left heel. The note referred to the registered nurse's note for details. Resident #3 was to be followed by the wound clinic. No further wound documentation was noted.<br><br>During an interview on 11/20/24 at 2:35 p.m., staff member D said she would usually see and assess a new admission to the facility within 72 hours. She would place the orders at that time, or they would come from the hospital. Staff member D said residents should come with orders from the hospital on admission and then they are reviewed by her. She will look at resident skin ulcers and assess them, then place orders. Staff member D said she documents her wound assessments in the patient history.<br><br>During an interview on 11/25/24 at 3:40 p.m., staff member B said she was responsible for providing wound oversight. If the wound occurred in the facility, she would initially stage the wound, and the resident would be sent out to the wound clinic. Staff member B said staff member D would assess the wounds if a concern was identified. Wound orders were ordered and in place for a duration of 14 days as a flag to reassess and check to see if treatment was beneficial and appropriate for the wound. Staff member B said through the immediate jeopardy process, it was discovered the wound notes from the physician were limited for the amount of information provided, which was due to the provided space. Staff member B said she provided education for staff member D on how to write her progress notes for wounds. |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32998<br><br>Based on observation, interview, and record review, facility failed to identify, assess, document, measure, obtain, and follow physician orders for wound care for 3 (#s 2, 3, and 4) of 6 sampled residents. The facility failed to identify changes in the resident's skin status, which occurred over a short period of time, and failed to address wound changes timely for the provision of medical assistance or needed interventions. The facility failed to have a wound management system in place that provided the necessary oversight for care and treatment of wounds, based on professional standards of practice. Resident #4 was admitted to the facility with multiple wounds in various stages of breakdown, and the wounds were documented to be getting worse, in part due to his uncontrolled pain.<br><br>On 11/20/24 at 2:02 p.m. an Immediate Jeopardy was announced to the Administrator and Director of Nursing for F686- Pressure Ulcers Care and Prevention. The Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of K, and upon verification for the removal of the immediacy, may be lowered to an H. An acceptable plan for the Removal of Immediacy was approved on 11/25/24 at 5:16 p. m.<br><br>Findings include:<br><br>1. During an interview on 11/18/24 at 3:56 p.m., NF1 said she was contacted on 11/10/24 that resident #4 had passed away within 24 hours of being admitted to the hospital. She then contacted a 3rd party to perform an autopsy due the physician report. NF1 said the physician reported, It was the worst case of neglect they have ever seen. NF1 said, His (#4's) wounds were horrific, and he basically had no backside; his arms and feet were involved. His official Cause of Death was severe sepsis.<br><br>During an interview on 11/20/24 at 9:49 a.m., staff member F said she was working the day resident #4 was admitted to the facility. When resident #4 arrived at the facility, he refused to move himself from the stretcher to the bed. Staff member F said he was in extreme pain. Staff member F said the facility was aware resident #4 had severe wounds when the facility agreed to admit him. Staff member F said, He basically had no skin on the back of his legs, his pannus, and his back. Staff member F said resident #4 had so many wounds over his body she asked for help to do his admission skin evaluation.<br><br>During an interview on 11/20/24 at 2:35 p.m., staff member D said resident #4's wounds were primarily sheering wounds on his buttocks, on his legs and one under his pannus. The wounds were not pressure wounds, and there was never any discharge from the wounds. Resident #4's wounds would bleed, but were not infected. Staff member D said resident #4 refused all treatments and medications over a weekend. Staff member D said the facility could not get resident #4 to participate in therapies or get out of bed. Staff member D said resident #4's wounds were not infected when he was sent to the emergency department for further evaluation.<br><br>During an interview on 11/20/24 at 3:28 p.m., staff member B said resident #4 would refuse cares and pain medications. His wounds were all superficial and would bleed. Staff member B said one weekend he refused all cares and medications; he began to decline. Staff member B said the resident was in pain, and the facility sent him to the emergency department for an evaluation. He was admitted to the hospital.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of resident #4's facility Order Summary Report, dated 10/1/24 through 11/9/24 showed an order for resident #4 for turning and repositioning as appropriate, and dressing changes were ordered as needed for wound care, for 14 days. The physician order did not give a specific timeframe for turning and repositioning, and the nursing staff neglected to consistently document resident #4's response or refusals for the repositioning or participation in care. Nursing staff neglected to ensure the wound care orders were in place for the routine changing of the dressings and treatment of resident #4's wounds.<br><br>Review of resident #4's Admission Assessment, dated 10/3/24, showed the following wounds:<br><br>- The resident had a Stage II pressure injury to his left hip measuring 14 cm x 5.5 cm.<br><br>- Three Stage II pressure injuries to his right buttock, one measuring 2.5 cm x 1.5 cm, one 2.5 cm x 2.8 cm, and another that was 2.5 cm x 3.0 cm.<br><br>- One Stage II pressure injury to the resident's left buttock measuring 2.5 cm x 3.0 cm.<br><br>- Multiple skin tears to the resident's left forearm, to both lower extremities, to the resident's left thigh, and to the resident's abdomen. No measurements, description or number of skin tears was documented.<br><br>- There was no documentation at that time of admission for resident #4's left scapular wound and no documentation of wound assessment for drainage or odor present.<br><br>Review of resident #4's skin/wound notes, from 10/17/24 through 11/1/24, showed the following measurements:<br><br>10/17/24;<br><br>- Stage II right buttock, 5.0 cm x 4.0 cm x depth of 0.1 cm<br><br>- Right thigh, 3.0 cm x 3.0 cm<br><br>- Right thigh, 2.5 cm x 2.5 cm<br><br>- Posterior shin/calf, 9.5 cm x 3.5 cm<br><br>- Left buttock, 2.5 cm x 3.0 cm x 0.1 cm<br><br>10/25/24;<br><br>- Right buttock, 5 cm x 4 cm x 0.1 cm<br><br>- Left buttock, 2.5 cm x 3 cm x 0.1 cm<br><br>- Right thigh, 2.5 cm x 2.5 cm<br><br>- Right thigh, 2.5 cm x 2.5 cm<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | - Posterior shin/calf, 7.5 cm x 3.5 cm<br><br>11/1/24;<br><br>- Stage II right buttock, 3.5 cm x 4.5 cm x 0.1 cm<br><br>- Stage II left buttock 5.3 cm x 3.0 cm x 0.1 cm<br><br>- Stage II right buttock, 2.0 cm x 3.2 cm x 0.1 cm<br><br>- Stage II right buttock, 5.0 cm x 3.0 cm x 0.1 cm<br><br>- Right thigh, 3.0 cm x 3.4 cm, skin tear<br><br>- Left lower leg, 8.0 cm x 4.1 cm<br><br>Resident #4's skin/wound notes showed a progression of an increase in size over the duration of his stay within the facility. The inconsistent documentation and care provided for the wounds contributed to resident #4's worsening wounds and severe pain he experienced.<br><br>Review of resident #4's Weekly Skin Observations, dated 10/9/24 through 10/30/24 showed the following:<br><br>10/9/24;<br><br>- Pannus skin tear. There were no measurements documented.<br><br>- Buttock skin tear. There were no measurements documented.<br><br>- Documentation buttock wounds, scapular wounds, leg wounds and hip wounds were not documented. No measurements, wound types and status were documented.<br><br>10/16/24; All wounds listed as skin tears. There were no measurements documented<br><br>10/23/24;<br><br>- All wounds were listed as abrasions The sizes were documented as:<br><br>- Right iliac front, 5 cm x 3.1 cm x 0.1 cm<br><br>- Left iliac front, 4.0 cm x 2.5 cm x 0.1 cm<br><br>- Left hip, 5.0 cm x 3.0 cm x 0.1 cm<br><br>- Left lower leg rear, 8.1 cm x 4 cm x 0.1 cm<br><br>- Stage II right buttock, 12.7 cm x 5.5 cm x 0.1 cm<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | - Stage II left buttock, 5.0 cm x 3.0 cm x 0.1 cm<br><br>- No documentation of any wound conditions were noted, and the documentation was signed off on 10/30/24.<br><br>10/30/24;<br><br>- Pressure right buttock, 12.7 cm x 5.5 cm x 0.1 cm, no staging<br><br>- Pressure left buttock, 5.0 cm x 3.0 cm x 0.1 cm, no staging<br><br>- Left Lower leg rear, 8.0 cm x 4.1 cm, abrasion<br><br>- Other left lower abdomen, abrasion, no measurements<br><br>- Other, right upper thigh skin tear, 3.0 cm x 3.5 cm<br><br>Skin observation documentation showed the inconsistency of the identification of each wound area and the inconsistency of documentation with assessments of wounds for type of wound, measurements, and if odor was present.<br><br>Review of resident #4's care plan, provided by the facility, showed a problem of Stage II biateral buttock and left hip pressure ulcer with an intervention initiation date of 10/3/24, and weekly skin assessments and staff were to monitor for signs and symptoms of infection. On 10/21/24 interventions of nutritional supplements, and staff to encourage turning and repositioning were added. No interventions for repositioning or nutritional supplements were in place until 18 days into his stay.<br><br>Record review of an emergency department (ED) physician note for resident #4, dated 11/9/24, showed a chief complaint of decreased responsiveness, not eating or taking his medications. The ED physician noted resident #4 arrived on 4L of oxygen via nasal cannula and had an oxygen saturation of 87 to 88%. Resident #4 would respond to painful stimuli. When moved from the EMS gurney to the hospital bed, the patient yelled Jesus Christ. The nursing home had reported to the ED that resident #4 had two large decubitus ulcers only, one on his sacrum buttocks, and the other on his left shoulder.<br><br>Resident #4's physical exam showed:<br><br>.Constitutional:<br><br>General: He is in acute distress; Appearance: He is obese. He is ill-appearing and toxic-appearing; Comments: Patient [NAME] of yeast his hygiene is poor and the patient is bedridden.<br><br>HENT: Head: Normocephalic and atraumatic; Comments: there was a large scab matted with hair on the crown of the scalp that was removed and there is a shallow ulcer that peers to be a basal cell carcinoma.<br><br>.Assessment/Plan:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | AMS, decreased level of responsiveness, likely severe sepsis . The patient's pressure sores and decubitus sores on his buttocks sacral region and thighs were seen cultured and photos were taken; the pressure sore on the left scapular region also cultured and pictures taken and there is a pressure sore blister with blood on the right heel, and there is a sore on the left posterior leg. Also in the differential diagnosis besides severe sepsis have to asked to be the consideration of wound botulism.<br><br>.Final Impression<br><br>1. Severe sepsis with organ failure<br><br>2. Decubitus ulcers and pressure sores the buttocks sacrum and left scapular region, Appear to be stage III.<br><br>3. Dehydration<br><br>4. Overall this is very concerning for neglect. [sic]<br><br>Record review of resident #4's death summary, dated 11/10/24, showed:<br><br>.Admission Diagnosis: sepsis<br><br>Discharge Diagnosis: Severe sepsis with septic shock. Acute kidney injury. Acute encephalopathy<br><br>Hospital Course: Patient was transferred to our institution form [sic] an outside hospital less than 24 hours ago with septic shock. Source was soft tissue and skin infections secondary to multiple decubiti ulcers, some of which were gangrenous. Despite aggressive medical therapy with volume resuscitation, antibiotics and vasopressor support the patient's hemodynamics continued to worsen. He was encephalopathic the entire time . his illness caused his death at 4:41 a.m .<br><br>2. During an observation and interview on 11/20/24 at 9:49 a.m., resident #2 was observed to be in her room and reclined on her bed. Resident #2 had both heels resting on the surface of the bed, with no padding or offloading of her heels noted. The room had a strong foul odor upon entering from the hallway. Staff member F donned gloves and removed the dressings from both of the resident's feet. The right heel wound was cleaned, and a small amount of tissue was debrided from around the wound. The right heel wound was dry, measured 9.5 cm x 4.5 cm, and had a foul odor. The left heel wound was dry, measured 12 cm x 4.5 cm, and had a foul odor. Staff member F cleaned the wounds with saline, applied betadine with a swab, and wrapped both feet with kerlix gauze. Staff member F said she does not measure the wounds with each dressing change but will measure them weekly when she does a big evaluation. She does not stage (assess severity) the wounds because it is beyond her scope of practice. Staff member F said the physician order was for a dressing change daily, and she will document the dressing change was performed in the nursing note. Resident #2 stated she acquired the wound from the bed, while in the facility. She stated she walked into the facility for rehab and, now she is in a wheelchair. She was no longer able to walk or stand on her feet. Staff member F then corrected resident #2 stating; she acquired the wounds while in the hospital. Resident #2 was noted to be shaking her head from side to side in disagreement. Staff member F said resident #2 had just finished antibiotics for her heel wounds.<br><br>(continued on next page) |

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| | 275134 | A. Building<br>B. Wing | 11/25/2024 |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 11/20/24 at 2:35 p.m., staff member D said resident #2 has heel wounds because she refuses to offload her heels. Staff member D said resident #2 has had an odor from her wounds for quite a few weeks, and the wound clinic did not recommend any antibiotics. The wound clinic will not debride #2's wounds until she saw a vascular surgeon for an evaluation. Staff member D said the antibiotics she was given were for a urinary tract infection, not for her wounds.<br><br>During an interview on 11/21/24 at 12:21 p.m., resident #2 said she was admitted to the facility for rehabilitation and strengthening. She was receiving physical therapy services and was getting stronger. Resident #2 said the facility then fired the physical therapist, and she did not receive therapy services for several weeks, until a new physical therapist was hired. She spent that time sitting in a chair or lying in bed, causing her to develop pressure wounds on her heels. Resident #2 said when she was admitted to the hospital for her kidney failure, her wounds would be debrided. Resident #2 said she is no longer able to walk because of the wounds on her heels.<br><br>During an interview on 11/25/24 at 3:49 p.m., staff member B stated resident #2 found to have a non-trauma related fracture to her foot, due to deterioration of her bones. There was a concern with the aeration of the tissue in her foot. Resident #2 requested to be transported to the facility so she could be near the physician treating the wounds.<br><br>Review of resident #2's Skin/Wound Notes showed the following:<br><br>9/2/24;<br><br>- Right foot 3rd digit measuring 1.0 cm x 1.0 cm<br><br>- Left foot 2nd digit measuring 0.3 cm x 0.3 cm<br><br>- No documentation of the wound type or description of the wound was present.<br><br>9/8/24;<br><br>- Right 3rd digit measuring 0.5 cm x 0.5 cm<br><br>- Left 2nd digit measuring 0.2 cm x 0.2 cm<br><br>- Blister to right heel measuring 4 cm x 2.4 cm<br><br>-- No documentation of wound type or description of the wound was present.<br><br>9/14/24;<br><br>- Right foot 3rd digit measuring 1.5 cm x 0.3 cm x 0.4 cm depth<br><br>- Left foot 2nd digit measuring 0.5 cm x 1 cm<br><br>- No documentation of wound type or description of the wound was present. No documentation for the right heel was present.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 9/28/24;<br><br>- Hospital acquired pressure wounds to bilateral feet.<br><br>- Right heel 0.8 cm x 0.5 cm eschar present, Unstageable<br><br>- Left heel 2.7 cm x 1.5 cm eschar present, Unstageable<br><br>- No documentation of right 3rd digit and left 2nd digit, no documentation of wound description was present.<br><br>10/6/24;<br><br>- Hospital acquired pressure wounds to bilateral feet.<br><br>- Right heel measuring 0.7 cm x 0.6 cm eschar present<br><br>- Left heel measuring 2.5 cm x 1.3 cm eschar present<br><br>- No documentation of right 3rd digit and left 2nd digit was noted in any of the further skin/wound notes.<br><br>10/17/24;<br><br>- Hospital acquired pressure wounds to bilateral feet.<br><br>- Right heel measuring 0.7 cm x 0.6 cm<br><br>- Left heel measuring 2.8 cm x 1.8 cm<br><br>10/25/24;<br><br>- Hospital acquired pressure wounds to bilateral feet.<br><br>- Right heel measuring 0.7 cm x 0.6 cm<br><br>- Left heel measuring 3 cm x 3 cm<br><br>- Left heel wound was increasing in size.<br><br>10/28/24;<br><br>- Hospital acquired pressure wounds to bilateral feet<br><br>- Wound to left heel measuring 8.5 cm x 4 cm. Continues to have foul odor with moderate drainage, wound bed eschar. Continues on antibiotic treatment.<br><br>- Left heel wound increased in size significantly and now has drainage with a foul odor.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 11/1/24;<br><br>- Right heel measuring 5.8 cm x 5.5 cm eschar present.<br><br>- Left heel measuring 9 cm x 4.5 cm. eschar present. No odor<br><br>- Both heel wounds were increasing in size.<br><br>11/6/24;<br><br>- Right heel measuring 11.4 cm x 6.3 cm<br><br>- Left heel measuring 11.5 cm x 5 cm<br><br>- Both heel wounds were increasing in size.<br><br>11/14/24;<br><br>- Hospital acquired pressure wounds to bilateral feet.<br><br>- Right heel measuring 11.1 cm x 5.6 cm<br><br>- Left heel measuring 11.8 cm x 4.9 cm<br><br>Skin/wound notes show a progressively increasing size and worsening condition of the wounds.<br><br>Review of resident #2's Weekly Skin Observation showed the following:<br><br>8/16/24. - Left toe injury no measurements<br><br>8/23/24 - Right 2nd toe no measurements<br><br>8/30/24<br><br>- Right knee measuring 2 cm x 1.5 cm<br><br>- Right toe measuring 2 cm x 1 cm<br><br>9/7/24 - Right toe pressure wound measuring 0.2 cm x 0.2 cm x 0.1 cm<br><br>9/27/24<br><br>- Right heel measuring 2.7 cm x 1.5 cm eschar present, no odor<br><br>- Left heel measuring 0.8 cm x 0.5 cm eschar present, no odor<br><br>10/7/24 - Left and Right heels, pressure, suspect for deep tissue injury<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 10/11/24 - Left and Right heels, pressure, suspect for deep tissue injury<br><br>10/19/24 - Left heel pressure. NA for stage<br><br>10/26/24<br><br>- Right heel pressure measured 5 cm x 4 cm x .5 cm. Stage III<br><br>- Left heel pressure measured 5 cm x 3 cm x .5 cm. Stage III<br><br>11/2/24 - Left and Right heels pressure, Stage III. No measurements<br><br>11/9/24 and 11/16/24 - Right and Left heels pressure. No measurements or staging<br><br>45448<br><br>3. During an interview on 11/20/24 at 9:49 a.m., staff member F said resident #3 was able to walk prior to his hip fracture. Staff member F said resident #3 was noted to have a small area on his heel that looked like a sheer injury. The following week, the area had increased in size, and eventually the injury required surgical debridement.<br><br>During an interview on 11/20/24 at 2:35 p.m., staff member D said resident #3 started having skin issues following his hip fracture. He was having another resident with a scooter, pull him back to the facility, in his wheelchair. He fell out of his wheelchair. Staff member D said when he returned to the facility, following the repair of his hip, she ordered an air bed (pressure relieving) and to offload his heels. He quit eating and was referred to the wound clinic. Staff member D said he gave up (wanting to live his life) and made the decision to enter hospice.<br><br>During an interview on 11/21/24 at 9:35 a.m., staff member E said she cared for resident #3 often, as she was usually assigned the hallway where his room was located. Staff member E said resident #3 had facility acquired pressure ulcers. Staff member E said resident #3 would motor around in a wheelchair after his hip fracture and was quite social. Staff member E said resident #3 declined very quickly after the pressure ulcers were identified, and she felt he did not want to go on, and just gave up.<br><br>Review of resident #3's EMR documentation, showed:<br><br>8/4/24 - The CNA found serosanguineous fluid dried to the left sock, in the heel area. The sock was removed, and a large popped blister, was noted on the left heel. Nursing noted the wound would be assessed by IDT on Monday. No IDT notes with assessment were provided.<br><br>8/7/24 - Weekly skin assessment showed a left heel popped blister measuring 3.2 cm x 7.2 cm. No description of a wound assessment or drainage was noted.<br><br>8/14/24 - The weekly skin assessment showed a right buttock pressure wound measuring 3 cm x 2.2 cm x 0. 1 cm, Stage II, and a left heel deep tissue wound, measuring 4 cm x 5.2 cm x 0.1 cm. No wound assessment or drainage was noted.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 8/16/24 - The skin/wound note showed, deep tissue injury to left heel and pressure ulcer to right buttock. Left heel measuring 2.7 cm x 5 cm. Skin around the wound is intact and healthy. Pressure ulcer to right buttock 1. 5 cm x 1.8 cm x .01 cm. Wound bed slough, light serous drainage, no odor. Skin around wound was reddened.<br><br>8/18/24 - The skin/wound note showed, pressure ulcer on right buttock was cleansed, and a border dressing was applied. The wound had slough, light serous drainage, and an odor was present. No documentation was provided for physician notification. Change in size, depth, or surrounding tissue was not documented. No documentation for the left heel wound was found.<br><br>8/19/24 - The skin/wound note showed, pressure ulcer on right buttock was cleansed and a border dressing was applied. The wound had slough, light serous drainage, and an odor was present. No documentation was provided for a physician notification. Change in size, depth, or surrounding tissue was not documented. No documentation for a left heel wound was found.<br><br>8/21/24 - The weekly skin assessment showed a right buttock pressure wound 3.5 cm x 5 cm x 0.2 cm, Stage II, and a left heel deep tissue injury measured 5.25 cm x 6.25 cm x 0.1 cm. No wound assessment or drainage was noted.<br><br>8/28/24 - A general progress note showed, a dressing change was made to the right buttock per physician orders. Eschar was covering the wound bed, no scant drainage, no odor, and no signs or symptoms of infection were noted. No documentation for the left heel wound was found. The weekly skin assessment showed a right buttock pressure wound with no measurements, and a left deep tissue would with no measurements. No documentation of a wound assessment or drainage was noted.<br><br>8/31/24 - The skin/wound note showed, a certified wound clinician assessed the resident's wound. New orders were received for a deep tissue injury to the left heel and unstageable pressure ulcer to the right buttock. Deep tissue injury to the left heel measuring 4 cm x 4 cm, eschar was on the wound bed, no drainage was noted, foul odor, and wound edges were clean and intact. Dakins solution applied wet to dry as a dressing to encourage debridement. Pressure ulcer to the right buttock measuring 5 cm x 3 cm x 5 cm, eschar was on the wound bed, light serous drainage, edges were undefined, no odor was present. The skin around the wound was healthy. Cleanse the area with normal saline or wound cleaner, apply betadine to wound bed, skin prep to wound edges, and leave wound open to air. A referral to wound clinic for consult was made.<br><br>9/5/24- Resident #3 was transferred to the emergency department for evaluation of an altered mental status. He was admitted to the facility with a diagnosis of acute osteomyelitis of the left ankle and foot, related to his left heel wound.<br><br>9/24/24 - The resident returned to the facility, from the hospitalization . The weekly skin assessment showed a coccyx wound measuring 1 cm x 0.4 cm, a right buttock pressure wound that measured 6 cm x 8.5 cm x 1. 8 cm, and a left heel pressure wound that measured 4.2 cm x 2.6 cm x 0.5 cm. No documentation of a wound assessment or drainage was noted. The resident had a pressure sore to the sacrum and left heel, and a wound vac treatment was in place.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 9/28/24 - The skin/wound note showed, the Right buttock wound measured 6 cm x 8.5 cm x 1.8 cm, had 100% granulation, the wound edges were defined, and there was sanguinous drainage with no odor. The surrounding tissue was healthy and pink. The left heel wound measured 4.2 cm x 2.6 cm x 0.5 cm, 100% granulation, the wound edges were defined, and there was sanguinous drainage with no odor. The surrounding tissue was healthy and pink. The resident was followed by the wound clinic for evaluation and treatment. The note showed, resident #3's . wounds are related to a hospital acquired stage IV pressure ulcer to the right buttock and left heel with surgical debridement. [sic]<br><br>10/1/24 - The weekly skin assessment showed a right buttock pressure wound and a left heel wound. No documentation was present for a coccyx wound, and there was no documentation of wound assessments or drainage noted.<br><br>10/6/24 - A general progress note showed, while changing the wound vac on the buttock, nursing noted a red and open area on resident #3's coccyx. The area was cleaned with normal saline, and a Tegaderm was applied until the area could be assessed for treatment by the IDT team. A small dark area to the right heel, believed to be remnants from when the heel was compromised previously, was noted. The ADON and provider were notified. No measurements of either the coccyx or the right heel were documented. No IDT notes were provided that addressed treatment or assessment of the coccyx wound.<br><br>10/8/24 - A general progress note showed, the newest wound on resident #3's coccyx appeared unchanged. There was no description or measurements documented.<br><br>10/11/24 - The weekly skin check showed a right buttock pressure wound, a left heel pressure wound, both Stage IV, and a sacrum pressure wound, Stage II. No wound measurements, no wound assessments, and no wound drainage were noted.<br><br>10/12/24 - An alert note showed, related to resident #3's new wound to his coccyx, nursing staff continued to perform wound orders as directed and will continue to monitor. There was no notation of a left heel wound or buttock wounds, and no measurements were noted. The weekly skin assessment showed a right buttock pressure wound, and a left heel wound, both Stage IV and no measurements were documented. There was no documented coccyx wound, no documentation of wound assessments, or documentation of drainage, noted.<br><br>10/13/24 - A general progress note showed, nursing noted no change in wound status this shift. No documentation of individual wounds and assessments.<br><br>10/17/24 - The skin/wound note showed, resident #3's right buttock ischium wound measured 6 cm x 8.3 cm x 2.9 cm with 50% slough, and less than 50% bone is superficial, wound edges defined. The wound had sanguinous drainage with no odor, and surrounding tissue discoloration. The coccyx had a non blanchable reddened area, with measurements of 2.1 cm x 2.5 cm x 0.1 cm, Stage III wound. There was a small amount of serosanguineous drainage, no odor was present, 75% slough, 25% granulation, no odor, and discoloration of surrounding tissue. The left heel wound measured 4 cm x 5.9 cm x 0.3 cm with 0.2 cm undermining, 50% yellow slough and 50% exposed bone. The wound edges were defined, there was serosanguinous drainage with no odor, and the tissue surround the wound was healthy and pink.<br><br>10/18/24 - The weekly skin assessment showed a left buttock surgical incision, and a left heel surgical incision. No measurements or assessments were documented.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 10/25/24 - The skin/wound note showed, resident #3's right buttock ischium wound measured 6.7 cm x 6.2 cm x 3.5 cm, with undermining of 2.7 cm, 50% slough, less than 50% bone is superficial, wound edges were defined, sanguinous drainage with no odor, and there was surrounding tissue discoloration. The coccyx had a non-blanchable reddened area with measurements of 3.1 cm x 2.5 cm x 0.1 cm, Stage III wound with a small amount of serosanguineous drainage, no odor and slough 75%, 25% granulation, and discoloration of the surrounding tissue.<br><br>10/29/24- Resident #3 was admitted to hospice services.<br><br>11/4/24 - Resident #3 became nonresponsive and passed away at the facility.<br><br>Record review of facility provided documents showed, Provider Visit Note, dated 8/4/24, an evaluation of lab values only. The provider visit notes did not include any notes on #3's skin or wounds, the evaluation of the skin/wounds, or more detail related to them.<br><br>Record review of facility provided, Provider Visit Note, dated 9/30/24, showed a full readmission evaluation. The section for extremities/integumentary evaluation showed bilateral lower extremity weakness with resident #3 using a wheelchair for mobility and a wound vac was in place on the sacrum and left heel. The physician referred to the registered nurse note for details. No further wound documentation was noted.<br><br>Record review of facility provided, Provider Visit Note, for #3, dated 10/22/24, showed a 30 - day medical compliance visit. The section for extremities/integumentary evaluation showed 2+ bilateral lower extremity edema, and left upper extremity edema, and a wound vac in place on the sacrum and left heel. The notes referred to the registered nurse note for details. The note showed resident #3 was followed by wound clinic. No further wound documentation was noted.<br><br>During an interview on 11/20/24 at 2:35 p.m., staff member D said she would usually see and assess a new admission to the facility within 72 hours. She would place the orders for wound care at that time, or they would come from the hospital. Staff member D said residents should come with physician treatment orders from the hospital, on admission, and then they are reviewed by her. She will look at resident skin ulcers and assess them, then place physician orders. Staff member D said she documents her wound assessments in the patient history of the EHR.<br><br>During an interview on 11/25/24 at 3:40 p.m., staff member B said she was responsible for providing wound oversight. If the wound occurred in the facility, she would initially stage (determine severity) the wound, and the resident would be sent out to the wound clinic. Staff member B said staff member D would assess the wounds if a concern was identified. Through the immediate jeopardy process, surveyors discovered the wound notes and documentation for the physician was limited, related to the amount of information entered into the provided space (of the EHR). Staff member B said she provided education for staff member D on how to write her notes, in a progress note. |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>32998<br><br>Based on interview and record review, the facility failed to assess, document, treat, and monitor pain for 1 (#4) of 6 sampled residents. Resident #4 had severe pain during pressure ulcer dressing changes and turning and repositioning, which caused the resident to refuse care and dressing changes. Resident #4 expressed to the staff the pain regimen he had in place had not worked in relieving his pain during dressing changes and cares, resulting in increased skin breakdown. Resident #4 was transferred to the hospital on 11/9/24, and he passed away on 11/10/24. The facility failed to provide adequate pain management in a timely and effective manner to meet the resident's pain needs. The facility failed to identify and treat the resident's changes in condition as needed, and failed to utilize a root cause analysis process to determine the root causes of the resident's pain, for the identification and implementation of pain interventions.<br><br>On 11/20/24 at 4:52 p.m., an Immediate Jeopardy was announced to the Administrator and Director of Nursing for Pain Management. The Severity and Scope of the Immediate Jeopardy was at the level of J, lowered to a G upon the removal of immediacy. An acceptable plan for the Removal of Immediacy was approved on 11/25/24 at 5:16 p.m.<br><br>Findings include:<br><br>During an interview on 11/20/24 at 9:29 a.m., staff member F stated when resident #4 was admitted he had no skin on his buttock, back and arms. Staff member F stated resident #4 refused to get off the gurney when he first arrived at the facility due to the pain. Staff member F stated the resident was in so much pain he would refuse cares and dressing changes.<br><br>During an interview on 11/20/24 at 2:35 p.m., staff member D stated resident #4 had multiple wounds, which were caused by shearing (pressure and friction injuring the skin at the same time). Staff member D stated the resident had declined in the two days prior to being transferred to the hospital. Staff member D stated the wounds were infected toward the weekend and it was difficult to get him out of bed and to turn and reposition. Staff member D stated changes were made to the resident's pain regimen.<br><br>During an interview on 11/21/24 at 9:35 a.m., staff member E said she was concerned about resident #4's pain and pain control. Resident #4 complained of pain a lot, and he did not want to participate in therapy or other activities. He would not participate a lot in his care. Staff member E said she contacted staff member D, and she came in to talk with resident #4. Staff member E said after #4 was a resident for a week, the facility started working to adjust his pain medications. Staff member E said resident #4 had a pain patch, which was related to chronic pain, not the wounds, but he was only wanting Tylenol for his pain. She asked him why he only wanted Tylenol, and he said it was because the Norco was not effective for his pain. Staff member E said he had as needed pain medication ordered but it was not on a routine pain medication regimen for pain related to woundcare.<br><br>Review of resident #4's MAR/TAR, dated 10/1/24 through 11/9/24 showed:<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - From 10/4/24 through 10/31/24, resident #4 was on scheduled pain medication. Prior to 10/4/24 resident #4 was on as needed pain medication. The resident consistently reported the pain regimen was ineffective. There were multiple changes in the medication for pain management with no documentation of the effectiveness. The resident's pain ratings ranged from 1 to 10, with the higher number of 5-10 being consistently documented.<br><br>From 11/1/24 through 11/9/24, resident #4 was on scheduled pain medication, which showed pain ratings from three to six. On 11/5/24, the resident's pain medication was changed from hydrocodone to oxycodone. The resident's pain ratings ranged from two to nine during this time. The resident was not premedicated consistently prior to wound care, which caused the resident to refuse the wound care, and the wounds worsened and more wounds documented.<br><br>Review of resident #4's pain assessments were related to the time frames of every shift and scheduled times, and failed to consistently include documentation of complaints of pain at other times during the day, including time frames for wound care. The resident was not consistently medicated prior to wound care, and there were days, 11/6/24 and 11/7/24, when the pain medication was not administrated. There nursing staff were inconsistent in the documentation for the follow up for pain medication effectiveness.<br><br>On 11/4/24, the pharmacist completed a medication evaluation for pain. The pharmacist recommended adding an as needed dose of pain medication every four hours. After a couple weeks, the pharmacist recommended assessing the resident's total morphine equivalents per day and perhaps increase the dosage of the pain medication. There was no documentation of any pharmacy evaluations for the resident's pain concerns prior to 11/4/24.<br><br>Review of resident #4's non-pharmacological interventions for pain lacked consistent documentation for the effectiveness of the pain interventions offered or utilized.<br><br>Review of resident #4's Nursing Admission Assessment, dated 10/3/24, showed the resident had severe pain during dressing changes and turning and repositioning related to pressure ulcers. The resident reported constant pain rated at 5/10.<br><br>Review of resident #4's physician Order Summary Report, dated 10/3/24 - 11/9/24, showed the following medications for pain:<br><br>- 10/3/24 buprenorphine transdermal patch weekly 10 mcg/hr, order date of 10/3/24 with a start date of 10/7/24<br><br>- 10/3/24 buprenorphine transdermal patch weekly 10 mcg/hr, order date of 10/3/24 with a start date of 10/10/24<br><br>- 10/3/24 hydrocodone 5-325 mg (hydrocodone 5 mg-acetaminophen 325 mg) every 12 hours as needed for moderate pain. Discontinued on 10/4/24<br><br>- 10/4/24 hydrocodone 5-325 mg every eight hours for moderate pain. Discontinued on 10/4/24<br><br>- 10/4/24 hydrocodone 5-325 mg three times a day for pain-moderate pain control. Discontinued on 11/4/24<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - 10/4/24 oxycodone 5 mg every six hours as needed for pain-severe pain control. Discontinued on 10/4/24<br><br>- 10/24/24 Norco 5-325 mg ever four hours as needed for pain. Administer between scheduled doses. Discontinued on 11/4/24<br><br>- 11/4/24 oxycodone 5 mg every four hours as needed for pain. Discontinued on 11/4/24<br><br>- 11/5/24 oxycodone 5 mg every four hours as needed for pain rated at 5-10. Discontinued on 11/5/24<br><br>- 11/6/24 oxycodone 5 mg every four hours. Discontinued on 11/7/24.<br><br>Resident #4's pain regimen was consistently documented as ineffective based on the resident's complaints and refusals of wound care and turning and repositioning.<br><br>Review of resident #4's care plan, for pain, showed the following:<br><br>- Administer analgesic medications as ordered. Monitor/document side effects and effectiveness every shift (initiated 10/4/24)<br><br>- Ask physician to review medication if side effects persist (initiated 10/4/24)<br><br>- Review for pain medication efficacy. Assess whether pain intensity acceptable to resident, no treatment regimen or change in regimen required . therapeutic regimen followed, but pain control not adequate, changes required (initiated 10/4/24)<br><br>- Encourage repositioning every 1-2 hours (initiated 10/21/25)<br><br>- Monitor for increased pain or decline in status related to pain. (initiated 10/3/24)<br><br>Resident #4 did not have physician orders for pain medications after 11/7/24. The resident was transferred to the hospital on 11/9/24 where he passed away.<br><br>Review of the facility Policy, titled Pain Management, implemented on 1/2/24, showed:<br><br>- .1 a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated.<br><br>1 b. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs.<br><br>1 c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences .<br><br>8 a. Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences .<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Ivy at Deer Lodge | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 8 b. If re-assessment findings indicate pain is not adequately controlled, the pain management regimen and plan of care will be revised as indicated . |