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	12/03/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility staff failed to correctly position a mechanical lift sling to prevent an accident, which caused injury to a resident when she fell from the lift, for 1 (#5) of 14 sampled residents. This deficient practice caused the resident to experience pain, she had an injury to the head, and a fear of the lift, which has not subsided. Findings include:Review of a Facility Reported Event, for 2/18/25, showed resident #5 had fallen from a mechanical lift during a transfer from the bed to the wheelchair. The report showed a staff member had failed to hook the lift sling properly to the lift, causing resident #5 to fall to the floor. During an interview on 12/2/25 at 1:32 p.m., resident #5 stated, I remember that incident. Staff were getting me up, but they didn't hook the sling right. When they went to move me with the lift, I fell out of the sling and hit the bed, and then the floor. I had hit my head on the metal part of the bed. It hurt really bad. I had a giant goose egg on my head. It could have been worse.Review of resident #5's medical record progress notes showed:-2/18/25 at 10:00 a.m. - Res was found on the floor lying flat on her back with her head up next to her bed. Res was positioned underneath the hoyer lift. Cna's voice res was not properly positioned safely to hoyer pad when she fell from it. Res voices this was an accurate account of events . No bruising or injuries noted at time of assessment. [sic]-2/18/25 at 1:00 p.m. - Res noted to have a small nodule on her right middle head r/t s/p fall. Res voices her pain is at a 5.-2/19/25 at 2:00 p.m. - Res c/o upper to mid back pain r/t S/P fall on 2/18/25. VSS. She voices her pain is greater than 5. MD and family notified via voicemail and fax. She is transported to [Facility Name] via facility transportation. [sic]Review of a physician's note, for resident #5, dated 2/25/25, showed, PT reports last week at the [Facility Name] while transferring she was dropped. Pt reports nightly headaches and back pain since event. [sic]During an observation on 12/3/25 at 9:17 a.m., staff members F and Q were observed assisting resident #5 to get up for the day. Staff positioned resident #5 in the mechanical lift sling and began raising her from the bed. Resident #5 was holding on to the bars of the lift, and her hands were white from a tight grip. Resident #5 winced when staff started moving the lift. Once the staff moved her over her wheelchair, resident #5 grabbed the lift bar with both hands and became quiet. When staff pulled the sling out from under resident #5, she winced and stopped talking.During an interview on 12/3/25 at 9:42 a.m., resident #5 stated, I am most afraid when I don't know the staff or when I don't trust them. I double-check the straps every time I get transferred now. Social services never talked to me about the incident, and no one from the facility did. I am terrified, and it sucks. Review of a facility document titled Accidents and Supervision with a revision date of 5/16/25, showed: Policy: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s).2. Evaluating and analyzing hazard(s) and risk(s).Policy Explanation and Compliance Guidelines:The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. [sic]

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on observation, interview, and record review, the facility failed to identify psychosocial harm after a resident's traumatic experience and fall from a mechanical lift, and failed to provide medically necessary social services for 1 (#5) of 14 sampled residents. This deficient practice caused the resident to continue to be fearful of transfers with the lift and falling, which increased her anxiety. Findings include:During an interview on 12/1/25 at 1:03 p.m., resident #5 stated, I have a hard time with some of the staff. It is like they don't listen to me when I tell them how to do things. There are some staff here I don't trust.During an interview on 12/2/25 at 1:32 p.m., resident #5 stated, I remember the incident with the lift. Staff were getting me up, but they didn't hook the sling right. When they went to lift me, I fell out of the sling and hit the bed and then the floor. It hurt really bad. I didn't want to go to the clinic because I hurt so badly . I had a goose egg on my head. I am scared of falling from the lift again. I am even scared when they [staff] pull the sling out from under me. It really makes me nervous when the CNA who dropped me is getting me up. I spoke to [staff member B], and she said the situation was handled. I don't know what they [staff] consider handled.Resident #5 was able to recall the names of the two staff members performing the mechanical lift transfer and all details of the incident from 2/18/25.During an observation on 12/3/25 at 9:17 a.m., staff members F and Q were observed getting resident #5 up for the day. Staff positioned resident #5 in the mechanical lift sling and began raising her from the bed. Resident #5 was holding on to the bars of the lift, and her hands were white from a tight grip. Resident #5 winced when staff started moving the lift. Once the staff moved her over her wheelchair, resident #5 grabbed the lift bar with both hands and was quiet. When staff pulled the sling out from under resident #5, she winced and stopped talking. During an interview on 12/3/25 at 9:30 a.m., staff member F stated that resident #5 had shown signs of fear during transfers right after the incident happened. She [resident #5] has expressed fear of some staff members, . especially the one who dropped her. During an interview on 12/3/25 at 9:42 a.m., resident #5 stated, I am most afraid when I don't know the staff or when I don't trust them. I double-check the straps every time I get transferred now. Social services never talked to me about the incident, and no one from the facility did. I am terrified of falling, and it sucks. During an interview on 12/3/25 at 10:08 a.m., staff member P stated she did follow up with resident #5 after the incident with the lift. Staff member P stated she would document conversations with resident #5 in progress notes in resident #5's chart. Staff member P stated, She [resident #5] did request that the staff member responsible for the fall not work with her anymore, and to the best of my knowledge, she doesn't work with resident #5. I did not do a formal assessment for psychosocial harm or PTSD. I didn't realize she was afraid during transfers or scared of falling.During an interview on 12/3/25 at 11:46 a.m., staff member B stated staff member R . works on the 100 hall now. Staff member R knows she is not to care for resident #5. Staff member R was assisting resident #5 when she fell from the mechanical lift. Review of resident #5's medical record failed to show that any psychosocial assessments were completed after the fall from the lift on 2/18/25. Review of resident #5's medical record failed to show that any social service notes were documented after the fall from the lift on 2/18/25.A request was made on 12/3/25 for all social service progress notes for February and March 2025. There were no notes provided by the end of the survey period. Review of a facility document titled, Social Services, with an implementation date of 1/2/25, showed: Policy: The facility, regardless of size, will provide medically-related social services to each resident, to assist in attaining or maintaining the resident's highest practicable physical, mental, and psychosocial well-being.Policy Explanation and Compliance Guidelines:. 4. The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include:. k. Identifying and seeking ways to support (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	residents' individual needs through the assessment and care planning process.n. Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident.o. Meeting the needs of residents who are grieving from losses and coping with stressful events.7. The social worker, or social service designee, will monitor the resident's progress in improving physical, mental, and psychosocial functioning. [sic]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to ensure staff performed appropriate hand hygiene during meal service; failed to ensure laundry staff removed personal protective equipment appropriately after working with dirty laundry and linens; and failed to ensure staff performed all resident cares wearing personal protective equipment for Enhanced Barrier Precautions per CDC guidelines. These failures placed residents at increased risk for transmission of infectious organisms. Findings include:1. During an observation on 12/2/25 at 7:51 a.m., staff member I entered the kitchen without performing hand hygiene and came out with a drink which was delivered to a resident.During an observation on 12/2/25 at 7:59 a.m., staff member J exited the kitchen wearing gloves, served a drink to a resident, went back into the kitchen touching the door, did not change gloves or perform hand hygiene, and then continued with the meal service preparing drinks for multiple residents.During an observation and interview on 12/2/25 at 8:02 a.m., staff member K was observed entering the dining area and going through the kitchen door without performing hand hygiene. Staff member K then proceeded to assist four residents with meal setup without performing hand hygiene in between. Staff member K stated he should have used hand sanitizer between each resident.During an interview on 12/2/25 at 8:11 a.m., staff member M stated, You're supposed to use hand sanitizer every time between delivering trays.During an interview on 12/2/25 at 8:12 a.m., staff member I stated, I'm confused, I don't think you have to do hand sanitizer every time you go in the kitchen if you're just going to grab a tray, but yes, I guess you should.During an interview on 12/2/25 at 8:14 am, staff member K approached this surveyor and asked, Am I supposed to wash my hands every time I serve a meal? Staff member K stated, I should have been doing it, and walked away.During an interview on 12/2/25 at 8:23 a.m., staff member H stated his kitchen staff should be washing their hands in the sink when they first come through the kitchen door, but they don't have to perform hand hygiene in between serving trays. Staff member H stated he was not sure what the CNAs were supposed to do in between serving trays and asked this surveyor, What should we be doing? Staff member H stated he was going to talk to staff member A regarding what the policy was.During an interview on 12/2/25 at 8:59 a.m., staff member B stated hand sanitizer should be used every time before grabbing a new tray in between residents.Review of a facility policy, titled, Hand Hygiene, dated 1/2/25, showed the following: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.Review of a facility document, titled, Hand Hygiene Table, copyright 2025, showed the following: .Between resident contacts.Either Soap and Water or Alcohol Based Hand Rub. [sic] 2. During an observation and interview on 12/03/25 at 8:28 a.m., staff member N demonstrated the procedural process she would normally use when handling and cleaning dirty laundry. Staff member N removed her dirty gown, prior to removing her dirty gloves, after she had finished putting dirty laundry into the washing machine, thus contaminating her clothing. Staff member N stated the process of removing dirty PPE didn't seem right to her, then stated, But it was how I was shown when I started working here. During an interview on 12/3/25 at 8:45 a.m., staff member O stated she was aware of the process staff member N was using to remove PPE after performing laundry services for dirty clothing and bed linens, although the failed practice was not addressed by staff member O. During an interview on 12/3/25 at 8:54 a.m., staff member B stated she was not aware of laundry staff removing dirty PPE incorrectly. Staff member B stated she had not personally observed the infection control practices in the laundry room, but is aware she needs to in order to identify concerns.Review of a facility policy, titled, Personal Protective Equipment, dated 1/2/25, showed the following: This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff.5.Sequence of donning/removing PPE when using multiple types.b. Remove PPE in this order: gloves, goggles or face shield, gown.Perform hand hygiene after removing gown.7. Staff will receive training on the why, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	what, and how of PPE upon hire, annually, when new products are introduced, and as needed.3. During an observation on 12/3/25 at 9:17 a.m., staff members F and Q were assisting resident #5 with getting up for the day. Resident #5 had a wound and an indwelling catheter. Staff member F disinfected the lift and sling while staff member Q got resident #5 dressed and brief changed. Staff member Q was not wearing a protective gown. Staff member F assisted staff member Q with transferring resident #5 to her wheelchair. Staff member F was not wearing a protective gown. Neither staff member F nor Q wore protective gowns while performing personal care on resident #5, although the resident had a wound and an indwelling catheter.During an interview on 12/3/25 at 9:30 a.m., staff member F stated, I would use PPE for someone on EBP while doing direct catheter care or wound care, although this did not occur for resident #5. During an interview on 12/3/25 at 11:46 a.m., staff member B stated that staff should wear a protective gown and gloves for anyone on Enhanced Barrier Precautions. Staff member B said anyone with a wound or a catheter would be on Enhanced Barrier Precautions, and any staff completing wound care or doing anything with catheters should be wearing appropriate PPE.During an interview on 12/3/25 at 1:08 p.m., staff member B stated she followed CDC guidelines and the facility's policy for the use of EBP signs on residents' doors. Staff member B stated that staff must wear PPE when they are providing care to residents with wounds and catheters, but it was not always required for resident care. Staff member B stated, At the bottom of our PPE policy, it says the CDC guidelines, but it's confusing because they are different than our policy.Review of a facility document titled Enhanced Barrier Precautions with an implementation date of 1/2/25, showed: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Policy Explanation and Compliance Guidelines:1. Prompt recognition of need:.c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities.4. High-contact resident care activities include:a. Dressingb. Bathingc. Transferring d. Providing hygienee. Changing linensf. Changing briefs or assisting with toileting. [sic]

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure an assessment was completed to evaluate the safety of residents who desired to self-administer medications for 2 (#8 and #43) of 4 observed medication administration residents. Findings include: 1. During an observation on 12/2/25 at 7:45 a.m., staff member C prepared the following medications to administer to resident #43 orally: - finasteride 5 mg, - lisinopril 2.5 mg, - meloxicam 15 mg, - omeprazole 20 mg, - oxybutynin chloride 5 mg, - torsemide 20 mg, - tamsulosin 0.4 mg, - gabapentin 300 mg, - glipizide 10 mg, - vitamin B12 1,000 mcg, and - vitamin D3 2,000 units. During an observation on 12/2/25 at 7:55 a.m., staff member C left all of resident #43's oral medications on his bedside table and reminded him to take his medications. Staff member C then left resident #43's room and closed the door. During an interview on 12/2/25 at 7:59 a.m., staff member C stated resident #43 was cognitively intact and took his medications independently. She stated resident #43 had an assessment for self-administration of medications completed. During an interview on 12/2/25 at 1:33 p.m., staff member B stated she was looking for an assessment for self-administration of medications for resident #43 but had not found a completed assessment. Staff member B stated she would need to perform an assessment to ensure resident #43 was safe to self-administer his medications. 2. During an observation on 12/3/25 at 11:18 a.m., resident #8 was sleeping in her bed with a medicine cup approximately half full of multiple pills and capsules sitting on her bedside table. During an interview on 12/3/25 at 11:21 a.m., staff member D stated resident #8 did not have a self-medication administration assessment or provider order. Staff member D stated she would (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually check on resident #8 three or four times to make sure she takes her medications because she falls asleep a lot. Staff member D then immediately went into resident #8's room and woke her up to take her medications. Review of the facility policy titled, Resident Self-Administration of Medications, date implemented 1/2/25, showed: - . 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team. - . 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: - a. The medications appropriate and safe for self-administration; - . c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; and - .4. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to revise a resident's comprehensive care plan with interventions after an incident with a mechanical lift and failed to include psychosocial interventions for 1 (#5) of 14 sampled residents. Findings include: During an interview on 12/3/25 at 9:42 a.m., resident #5 stated, I am most afraid when I don't know the staff or when I don't trust them. I double-check the straps on the lift every time I get transferred now. Social services never talked to me about the incident, and no one from the facility did. I am terrified, and it sucks. During an interview on 12/3/25 at 10:08 a.m., staff member P stated, After an incident like hers [resident #5], I would usually go talk to her and enter a progress note. Staff member P said she was unaware that resident #5 was afraid of the lift or falling again and had not completed an assessment for psychosocial well-being.During an interview on 12/3/25 at 11:46 a.m., staff member B said each department was in charge of its section for care planning. Staff member B stated she was unsure if the care plan had been updated to reflect the interventions shown in the facility's investigation of resident #5's fall from the lift. Review of resident #5's comprehensive care plan, with a revision date of 2/28/25, showed: -Focus: [resident name] has had an actual fall with no injury r/t mechanical lift dysfunction.-Goal: [resident name] will resume usual activities without further incident through the review date.-Interventions: Educate staff on policy and procedure of using a mechanical lift (Hoyer lift). For no apparent acute injury, determine and address causative factors of the fall. Encourage diagnostic testing to rule out potential injury. Neuro-checks and vitals per protocol. Monitor/document/report PRN x 72h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. [sic]The comprehensive care plan failed to show interventions for her fear of falling from the lift again and her psychosocial needs. Review of a facility document titled Comprehensive Care Plans, with an implementation date of 1/2/25, showed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights, that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs.Review of a facility document titled Social Services with an implementation date of 1/2/25, showed: Policy: The facility, regardless of size, will provide medically-related social services to each resident, to assist in attaining or maintaining the resident's highest practicable physical, mental, and psychosocial well-being.k. Identifying and seeking ways to support residents' individual needs through the assessment and care planning process.n. Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure staff member C primed an insulin pen prior to administration of insulin for 1 (#43) of 4 observed medication administration residents. Findings include:During an observation and interview on 12/2/25 at 7:56 a.m., staff member C prepared resident #43's medication and insulin for administration. Staff member C stated they (nurses) did not prime insulin pens prior to dialing the insulin dosage for residents at this facility. She stated some facilities did prime insulin pens and other facilities did not prime insulin pens. Staff member C stated she was unsure what the facility's policy and procedure showed for insulin administration related to priming an insulin pen.During an interview on 12/2/25 at 8:51 a.m., staff member B stated per the facility policy and procedure, insulin pens were to be primed before dialing the dosage of insulin.During an interview on 12/2/25 at 9:05 a.m., staff member D stated the nursing staff were required to prime an insulin pen prior to dialing the insulin dosage into the pen. Staff member D stated she primes the insulin pen with 5 units of insulin.Review of the facility policy titled, Insulin Pen, date implemented 1/2/25, showed after attaching the pen needle:- .h. Prime the insulin pen:- i. Dial 2 units by turning the dose selector clockwise.- ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears.