

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 211 N Main St Ennis, MT 59729	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>45447</p> <p>Based on observation, interview, and record review, the facility failed to ensure MDS assessments were coded correctly for diagnoses for 1 (#5); and for bed rails for 3 (#s 8, 12, and 13) of 12 sampled residents for MDS accuracy. Findings include:</p> <p>1. Review of resident #5's Physician Office Clinic Note, dated 3/18/24, showed the physician added the diagnosis of Dementia under the section, Assessment/Plan.</p> <p>Review of resident #5's Quarterly MDS, with an ARD of 4/17/24, failed to show a diagnosis of Dementia on the assessment. The assessment had not been revised to show the new diagnosis of dementia.</p> <p>Review of resident #5's EMR showed documentation of a request to add Dementia to the resident's diagnosis list on 5/6/24, the first day of the survey.</p> <p>During an interview on 5/7/24 at 11:13 a.m., staff member F stated resident #5 definitely had a diagnosis of Dementia.</p> <p>During an interview on 5/7/24 at 2:35 p.m., staff member D stated to add a diagnosis to resident #5's diagnosis list, the provider needed to sign a form, or it needed to be discussed during medication reviews. Staff member D stated it looked like resident #5's diagnosis of Dementia never made it to her list after the provider visit on 3/18/24, thus it was not on the diagnosis list when staff member D went to complete the resident's diagnosis section of the MDS. Staff member D stated she did not think the facility had a fail safe in place to ensure new diagnoses were put in a resident's list after a provider visit.</p> <p>49554</p> <p>2. Review of resident #8's Quarterly MDS's, dated 11/22/23 and 2/14/24, showed section P restraints:</p> <p>1. Bed alarm. Not used.</p> <p>2. Chair alarm. Not used</p> <p>During an observation on 5/6/24 at 3:16 p.m., resident #8 was asleep in the recliner with a chair alarm under her.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 5/7/24 at 11:34 a.m., resident #8 was in her room being assisted by staff to get into her wheelchair. Staff member J explained, resident #8 attempted to get up on her own and was unstable, so they used the alarms to alert the staff that resident #8 was attempting to get up.</p> <p>During an interview on 5/7/24 at 2:39 p.m., staff member D stated, I don't think the (physician) orders are getting updated as they should be. We have been back and forth with the alarms for resident #8. I didn't realize they were using them again.</p> <p>Review of resident #8's physician orders, dated 7/18/23, showed, Fall alarm to be placed in wheel chair and/or recliner for resident safety due to frequent self transfers. Check to ensure in place.</p> <p>3. During an observation on 5/6/24 at 2:51 p.m., a half-bed rail was on the left side of resident #13's bed.</p> <p>Review of resident #13's MDS, with an ARD of 3/21/24, showed, Section P Restraints: Bed Rail Not Used.</p> <p>During an interview on 5/8/24 at 8:20 a.m., staff member I stated, I'm not sure why resident #13 has a bed rail .</p> <p>4. Review of resident #12's MDS showed, Section P restraints: bed rail used daily.</p> <p>During an observation on 5/6/24 at 2:53 p.m., resident #12 did not have a bed rail on her bed.</p> <p>During an interview on 5/7/24 at 2:39 p.m., staff member D stated resident #12's bed rail use on the MDS must have been an error in the MDS coding.</p> <p>During an interview on 5/8/24 at 8:25 a.m., staff member I stated, [Resident #12] has never had a bed rail on her bed to my knowledge.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>45447</p> <p>Based on observation and interview, the facility failed to implement the intervention of bed rails and update the care plan for use of the rails, for 1 (#16) of 5 sampled residents with bed rails. Findings include:</p> <p>During an observation on 5/6/24 at 3:05 p.m., resident #16 was sleeping in his bed. There were no bed rails on the bed.</p> <p>During an observation on 5/7/24 at 2:20 p.m., resident #16 was up in his wheelchair. Resident #16 did not have bed rails present on his bed.</p> <p>Review of resident #16's physician orders, dated 10/24/23, showed, .use of right bed side rail for bed mobility and repositioning to enhance independence, not being used as restraint .</p> <p>Review of resident #16's paper Care Plan, in a binder labeled, 'Hall1,' dated 2/28/24, showed, Side rail on bed per [Resident #16's] request; left side rail not being used as restraint method.</p> <p>During an interview on 5/7/24 at 3:23 p.m., staff member H stated she did not think resident #16 had bed rails, then she looked in the resident's EMR and stated it looked like there was an order for a bed rail. Staff member H stated resident #16 recently moved rooms, and she thought maintenance must not have set the bed rail up.</p> <p>During an interview on 5/8/24 at 8:20 a.m., staff member B stated resident #16 did not want the bed rails anymore, but there had not been an order to discontinue the bed rails. Staff member B stated the bed rails must not have been installed when resident #16 had moved rooms that past month.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>49554</p> <p>Based on observation, interview, and record review, the facility failed to revise care plans to reflect the medical status for 1 (#9) resident; and to reflect bed rail usage for 1 (#16) of 12 sampled residents for care plans. This had the potential to cause staff to provide inaccurate care to the residents. Findings include:</p> <p>1. Review of resident #9's physician's order, with a discontinued date of 4/12/24, showed, blood glucose check. Notify provider if greater than 400.</p> <p>Review of resident #9's comprehensive care plan, with a revision date of 5/6/24, showed, continue monitoring blood sugars as ordered.</p> <p>Review of resident #9's MAR showed resident #9's blood sugar had not been checked since 4/12/24.</p> <p>During an interview on 5/8/24 at 7:35 a.m., staff member F stated, We haven't been checking resident #9's blood sugar because hospice discontinued them.</p> <p>2. During an observation on 5/7/24 at 11:36 a.m., resident #9 was observed in a wheelchair in the Day Room.</p> <p>During an observation on 5/7/24 at 1:14 p.m., resident #9 was observed in a wheelchair in the dining room.</p> <p>During an interview on 5/8/24 at 8:20 a.m., staff member I stated, I think the wheelchair for resident #9 is fairly new. I think hospice brought the wheelchair in .</p> <p>Review of resident #9's care plan section, ADL and Function, with an initiation date of 3/20/24, showed, Intervention: Walking/Locomotion - Independent with walker.</p> <p>Review of resident #9's Significant Change MDS, with an ARD of 4/3/24, showed, section GG, mobility devices use walker. The facility did not update the care plan with the use of the wheelchair.</p> <p>45447</p> <p>3. During an observation on 5/6/24 at 3:05 p.m., resident #16 was sleeping in his bed. The bed did not have bed rails.</p> <p>During an observation on 5/7/24 at 2:20 p.m., resident #16's bed did not have bed rails.</p> <p>During an interview on 5/7/24 at 2:43 p.m., staff member D stated she was responsible for updating the residents' care plans and did so on the paper copies in the binders. Staff member D stated the care plans needed to be updated within 14 days of the MDS completion.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/8/24 at 8:20 a.m., staff member B stated herself, the MDS Coordinator, and Social Services staff were responsible for updating the residents' care plans quarterly. Staff member B stated resident #16 did not want the bed rails anymore, so they were taken off. Staff member B stated there must not have been an order obtained to discontinue the bed rail, and the paper care plan was not updated.</p> <p>Review of resident #16's paper Care Plan, in a binder labeled, 'Hall 1,' dated 2/28/24, showed, Side rail on bed per [Resident #16's] request; left side rail not being used as restraint method.</p> <p>Review of resident #16's Quarterly MDS, with an ARD of 4/10/24, showed bed rails were not used for the resident. When the resident did want the rails the facility failed to add them to the comprehensive care plan, and when the resident no longer wanted the rails, the facility failed to revise the care plan.</p> <p>Review of the facility's policy, Care Plans, revised 5/24/23, showed, . Care plans are a working document and will be updated weekly at the leadership meeting during resident update on Mondays; .</p>		