STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275144	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastern Montana Veterans Home	2000 Montana Ave Glendive, MT 59330

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48262 Based on observation, interview, and record review, the facility failed to honor dining preferences for 1 (#7) of 13 sampled residents. The deficient practice had the potential to impact the resident's health and well-being. Findings include: During an observation and interview on 10/22/24 at 9:07 a.m., resident #7 was sitting in her wheelchair in her room. Resident #7 began to transfer herself from her wheelchair to her reclining chair. Resident #7 stated she had just finished her morning breakfast. Resident #7 stated seven or eight weeks ago, one CNA and one nurse entered her room and woke her from a sound sleep, and said, Get up, get up. You're going to the dining room. Resident #7 stated she told the nurse and CNA she did not eat in the dining room, and the nurse replied, You will today. Resident #7 stated, I never go to the dining room because my husband was here for about seven years, and I watched him truly die of Parkinson's. Resident #7 stated towards the end of her husband's life she couldn't watch facility staff feed him. Resident #7 stated when she first moved into the facility she would go to the dining room for meals, but over a short period of time, resident #7 stated, All I could see was that circle of (residents) that they feed, and I just didn't like it, so I don't go to the dining room anymore for my meals. I eat in my room and that's the way I like it. During an interview on 10/22/24 at 3:05 p.m., Staff member L stated she was called on her radio on 8/22/24 by staff member N to come and assist her in resident #7's room. Staff member L entered resident #7's room and noticed the resident was upset. Staff member L stated resident #7 said she did not want to get up. Staff member L stated she tried to comfort the resident while staff member N was providing coping skills to the resident. Staff member L stated she was aware of resident #7's personal reasons as to why the resident did not eat meals in the dining room. Staff member L stated staff member N was also aware because staff member N stated to resident #7, Just don't look at the residents that need help and focus on your food. Staff member L stated staff member I was present in resident #7's room and told staff members L and N the resident needed to be taken to the dining room for breakfast. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24, at 4:17 p.m., staff member I reported on 8/22/24, the night shift nurse mentioned resident #7 had fallen out of her chair. Staff member I decided it would be best for resident #7 to go to the dining room for breakfast, to be monitored more closely. Staff member I asked staff member N to help get the resident ready and bring her to the dining room. Staff member I explained that as staff member N was helping the resident dress, staff member N had to call staff member I back into the room a few times because the resident resisted care. Staff member I and N tried explaining to the resident that she couldn't stay in her room alone because no one would be able to assist her if she needed help. Staff member I stated resident #7 reacted with resistance, but staff were accustomed to this and maintained a firm approach to get her ready for breakfast. Staff member I stated it was resident #7's preference to eat meals in her room. Staff member I stated, With [Resident #7] falling, I thought, oh she's confused somebody needs to help her. Staff member I stated she thought she was keeping resident #7 safe taking her to the dining room for her meal. Staff member I stated once resident #7 was served her meal in the dining room the resident tried to stand up unsteadily. Staff member I stated she then moved resident #7 to a regular chair instead of her wheelchair to keep her seated. During an interview on 10/24/24, at 9:45 a.m., staff member K stated two CNA's report to the dining room for resident meals, and one CNA is required to stay on the residential unit to pass meals to residents who want to eat in their room. A review of the facility surveillance footage, received on 10/24/24 from law enforcement, dated 8/22/24, showed staff member N pushed resident #7 in her wheelchair into the dining room for resident #7's morning meal. Resident #7 was seen moving her wheelchair with her feet, heading toward the dining room exit. Staff member N re-entered the dining room and grabbed the handles on the back of resident #7's wheelchair. Staff member I entered the dining room and directed staff member N and resident #7 over to a dining table in the middle of the room. Staff member N pushed resident #7's wheelchair to the dining table. Staff member N placed resident #7's wheelchair brakes on and attempted to transfer the resident to a stationary chair. Resident #7 was seen resisting the transfer by pushing the staff members hands away from her body. Staff member N and I then place their forearms under resident #7's upper arms. Resident #7 was seen attempting to resist the transfer by lifting her head and turning it to the right as she pushed staff member N and I's hands and arms away from her. Surveillance video did not show resident #7 attempting to stand on her own prior to being transferred to a stationary chair. Review of Resident #7's MDS with an ARD of 7/14/24, showed, the following: . Section C, BIMS score 15; cognitively intact. . Section GG, Functional Abilities and Goals: - eating; independent. Review of resident #7's care plan, with a revision date of 9/20/24, showed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: [Resident #7] has a physical functioning deficit related to osteoarthritis pain. Goal: [Resident #7] will maintain current level of physical functioning through next review. Date Initiated: 10/10/24.Interventions: Is independent in eating. Chooses to remain in room for meals. Date Initiated: 1/22/24. Focus: [Resident #7] has adjustment issues related to decline in level of independence, recent changes in environment and situation. Date Initiated: 02/17/24. Goal: [Resident name] will express needs/preferences. Date Initiated: 02/17/24. Intervention: Allow [Resident #7] to make daily decisions and allow independence as much as possible. Date Initiated: 02/17/24. [sic]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48262 Based on observations, interviews, and record review, the facility failed to protect a resident's right to be free from physical and psychosocial abuse by facility staff for 1 (#7) of 13 sampled residents, causing resident #1 skin injuries, ongoing fear, and inability to sleep, fearing the specific staff involved would return to the facility. Findings include: During an observation and interview on 10/22/24 at 9:07 a.m., resident #7 was sitting in her wheelchair in her room. Resident #7 began to transfer herself from her wheelchair to her reclining chair. Resident #7 stated seven or eight weeks ago, one CNA, and one nurse, entered her room and woke her from a sound sleep and said, Get up, get up. You're going to the dining room. Resident #7 stated she told the nurse and CNA she did not eat in the dining room, and the nurse replied, You will today. Resident #7 stated the nurse and CNA then proceeded to undress her. Resident #7 stated the staff were, Tearing off my nightgown. Resident #7 stated she told the nurse and CNA to, Stop it as she was resisting care. Resident #7 said the CNA that was in the room called another CNA by radio for help. Resident #7 said the second CNA entered the room and helped transfer the resident to her wheelchair and then left her room. Resident #7 stated she was then transported by wheelchair down to the dining room, but she resisted by putting her feet down to the floor to try and stop the wheelchair from moving. Resident #7 said she really did not remember much else after that because she was in such a state of shock. Resident #7 said it took her three or four nights to settle down because she thought the staff would come back and harm her. During an interview on 10/23/24, at 4:17 p.m., staff member I reported on 8/22/24 the night shift nurse mentioned resident #7 had fallen out of her reclining chair on 8/21/24. Staff member I decided it would be best for the resident to go to the dining room for breakfast, so the resident could be monitored more closely. Staff member I asked staff member N to help get the resident ready and bring her to the dining room. Staff member I explained that as the CNA was helping the resident dress, she was called by staff member N back into the resident's room a few more times because the resident was resisting. Staff member I and N tried explaining to the resident that she couldn't stay in her room alone because no one would be able to assist her if she needed help. Staff member I stated resident #7 reacted with resistance, but staff were accustomed to this and maintained a firm approach to get her ready for breakfast. Once in the dining room, resident #7 was served her meal but tried to stand up unsteadily. Staff member I stated she then moved resident #7 to a regular chair instead of her wheelchair to keep her seated. Due to this, the resident would be unable to leave the dining room area as she was not in her wheelchair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/24/24 at 2:30 p.m., staff member E stated on 8/22/24, resident #7 was sitting in her wheelchair crying at a desk located in the front office. Staff member E stated she stopped and spoke to resident #7 to make sure she was okay. Staff member E stated while speaking with the resident, staff member A approached her and resident #7 and asked if she would complete a skin assessment on resident #7. After resident #7 agreed to the assessment, staff member E transported resident #7 in her wheelchair to the bathroom located in the administration office. During the skin assessment of resident #7, staff member E found one bruise on the back mid right shoulder described as a dime in size and purple in color and one bruise on the outer right groin described as a quarter to nickel in size and purple in color. Staff member E stated resident #7 had scratch abrasions on her right forearm. Staff member E stated resident #7's skin assessment was completed on 8/22/24 shortly after the incident occurred and no medical treatment was required. A review of the facility surveillance footage received on 10/24/24 from law enforcement, dated 8/22/24, showed staff member N pushed resident #7 in her wheelchair into the dining room. Eight other residents were observed seated at dining room tables, each in their own wheelchair. Resident #7 appeared [NAME] sitting in her wheelchair with her hands resting in her lap. Resident #7 was left in her wheelchair in the dining room between two dining tables by staff member N. Staff member N then exited the dining room. Resident #7 was seen moving her wheelchair with her feet, heading toward the dining room exit. Staff member N re-entered the dining room and grabbed the handles on the back of resident #7's wheelchair. Staff member I entered the dining room and directed staff member N and resident #7 over to a dining table in the middle of the room. Staff member N pushed resident #7's wheelchair to the dining table. Staff member N placed resident #7's wheelchair brakes on and attempted to transfer the resident to a stationary chair. Resident #7 was seen resisting the transfer by pushing the staff members hands away from her body. Staff member N and I then placed their forearms under resident #7's upper arms. Resident #7 was seen attempting to resist the transfer by lifting her head and turning it to the right as she pushed staff member N and I's hands and arms away from her. Surveillance video did not show resident #7's meal at the dining table or resident #7 attempt to stand on her own prior to being transferred to a stationary chair. Review of resident #7's medical provider noted dated 8/22/24 at 4:53 p.m., showed: Assessment & Plan Offerred ED transfer after being transferred in rough fashion this AM by staff Staff have been suspended they transferred her rouhgly and are being investigated No ecchymosis today Pain seems more chronic than anything No further changes today [sic] Review of resident #7's Weekly Head to Toe Skin Check, dated 8/22/24, showed, . 3. Wound documentation and notes: bruise to right shoulder scratch to right forearm small bruise to right upper thigh. [sic] (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of resident #7's EMR medical provider note, dated 8/28/24 at 1:30 p.m., showed, . Patient was physically assaulted by three individuals at her nursing home, resulting in multiple bruises and emotional distress. She is fearful, especially at night, and is having difficulty sleeping. The incident has left [Resident #7] in a state of heightened fear and anxiety, particularly at night. She is constantly on edge, reacting to every sound and expressing fear that the perpetrators might return. This emotional distress has also affected her sleep; she has difficulty falling asleep and staying asleep due to her heightened fear and anxiety. She stated that she hears every footstep in her hallway she is constantly worried about the return of the perpetrators. [Resident #7]'s [family member] is also upset about the incident, which has caused [Resident #7] feelings of guilt and sadness. She expressed regret that despite moving to the nursing home for safety reasons, she does not feel safe. In terms of medication changes, [Resident #7] would like her quetiapine dosage to be increased at night to help with her sleep issues. Review of resident #7's care plan, with a revision date of 9/20/24 showed: Focus: [Resident #7] has a physical functioning deficit related to osteoarthritis pain. Goal: [Resident #7] will maintain current level of physical functioning through next review target date of 11/11/24. Interventions: Dressing assistance of one, able to stand to transfer independent or with assist x one. Not able to walk. Is independent in eating. Chooses to remain in room for meals. Focus: [Resident #7] has a behavioral complex care plan due to behavioral presentations as evidenced by periods of verbal behaviors towards others and tearful episodes with emotional dysregulation. Goal: [Resident #7] will not exhibit a behavioral decline through next review target date 11/11/2024. Intervention: If [Resident #7] cannot be redirected or calmed, and if safe to do so, staff to attempt to perform cares at a later time after [Resident #7] is calmer. [sic] Review of Resident #7's MDS with an ARD of 7/14/24, showed the following: . Section C, BIMS score 15; cognitively intact. . Section GG, Functional Abilities and Goals: - eating; independent. - upper body dressing; set up or clean up assistance. - lower body dressing; independent. - putting on or taking off footwear; independent. - personal hygiene; independent. - wheel 50 feet with two turns; independent. - wheel 150 feet; independent. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of a Facility Reported Incident, sent to the State Survey Agency, showed a staff to resident abuse report was submited for the interaction resident #7 had with facility staff on 8/22/24. The report showed the facility identified the abuse after it occurred, suspended the staff for resident protection, made the initial report of abuse to the State Survey Agency, investigated the event, and put corrective measures in place. The facility investigation failed to address root causes, and the fact multiple staff were involved, but all failed to intervene or stop the abuse from occurring at the time of the event, or report it as alleged abuse immediately after, in an attempt to prevent future recurrences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 48262 Based on observation, interview, and record review, the facility failed to review and update a comprehensive care plan for 1 (#8) of 13 sampled residents. The resident experienced grief and sorrow from the recent death of her husband. Findings include: During an observation and interview on 10/24/24 at 1:01 p.m., resident #8 was in her room sitting in a recliner with her legs elevated and a blanket on her lap. Resident #8 said she shared the room with her husband, but was fearful another resident would be moving in. Resident #8 said her husband passed away recently, and she really missed him. Resident #8's nose turned red as tears ran down her face. With her voice trembling she stated, It was really hard on him. Resident #8 then glanced over to a table stand which held a digital picture frame. Resident #8 looked at the pictures pass by as she wiped away her tears with a tissue in her hand. Resident #8 said facility staff had not spoken to her about her grief or her fear of a new roommate moving into resident #8's room. During an interview on 10/24/24 at 2:53 p.m., staff member A said she had visited with, and provided emotional support to resident #8 following the death of her husband. Staff member A said she was not aware resident #8's care plan had not been updated. Staff member A stated the facility's social services director had recently ended her employment, and the position has not been filled. Staff member A stated it was her responsibility to fulfill that position until a new employee was hired. Review of resident #8's care plan, with revision date of 8/21/24, failed to show a focus area related to grief due to the death of resident #8's husband. No interventions were found in resident #8's care plan related to coping with loss, grief, or loneliness.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 48262 Based on observation, interview, and record review, the facility failed to provide social services for a resident who suffered with grief and loss of a spouse, for 1 (#8) of 13 sampled residents. Findings include: During an observation and interview on 10/24/24 at 1:01 p.m., resident #8 was in her room sitting in a recliner with her legs elevated, and a blanket on her lap. Resident #8 said she shared the room with her husband, but was fearful another resident would be moving in. Resident #8 said her husband passed away recently and she really missed him. Resident #8's nose turned red as tears ran down her face. With her voice trembling she stated, It was really hard on him. Resident #8 then glanced over to a table stand which held a digital picture frame. Resident #8 looked at the pictures pass by as she wiped away her tears with a tissue in her hand. Resident #8 said facility staff had not spoken to her about her fear of a new roommate moving into resident #8's room. Resident #8 said the facility had not provided any grief support since the passing of her husband. During an interview on 10/24/24 at 2:53 p.m., staff member A said she had visited with, and provided emotional support to resident #8 following the death of her husband. Staff member A said she did not document in the EMR her interactions when talking with resident #8. Staff member A said resident #8's family is very involved with her care and she would reach out to resident #8's [family member] to see what services would be best for the resident. Review of resident #8's care plan with a revision date of 8/21/24, showed resident #8's care plan was not updated addressing the recent loss of her husband, and no interventions were put in place to help the resident cope with grief and loneliness. The emotional distress concerns were not identified timely and addressed thoroughly by the facility or social services. A record review showed resident #8's spouse passed away in September 2024.