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	06/19/2025

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

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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. Based on record review, the facility staff assigned to a resident neglected to ensure he received necessary ADL care and was left in bed for an extended period of time without help. The resident experienced pain, distress, and skin abrasions from the event, for 1 (#4) of 5 sampled residents. Findings include: Review of a Facility Reported Incident, dated 3/6/25, showed resident #4 was left unattended in his room. The resident was residing on the special care unit, and he was not provided cares by CNAs (NF10 and NF11) working on the unit. Review of resident #4's nursing progress notes, dated 3/6/25 at 11:42 a.m., showed: CNA called this nurse to resident's room. Upon entering, this nurse noted resident lying on his side at the foot of the bed between the mattress and the footboard. Resident's Left arm was bent and caught between mattress and footboard, elbow touching the floor. Resident screaming and crying, very combative to all staff. Resident did not want to be touched or moved. Resident was covered in BM, as was the floor, bed, and floor mats. Bed was noted to be high, except the foot of the bed. Resident was assisted from bed to floor by this nurse and 3 CNAs. Skin tears noted to back of left hand by thumb, left wrist, and RFA. Dark purple bruising noted to back of left hand. Large dark-colored mark noted to Left hip with an indentation in the middle, likely from pressure. 2 other nurses came to assist with cleaning the resident up and dressing skin tears. Skin tears cleansed with soapy water. Adaptic applied, covered with silicone bordered gauze. Resident rolled onto a blanket and lifted x4 staff onto bed. Resident very combative during cares, hitting staff and kicking staff, nearly kicking staff in the face [sic] Review of NF10's witness statement, written by NF4, dated 3/6/25, showed: . Resident [#4] door was cracked all night so staff could check on him. ½ to 1 hr checks were done thru out night. Approximatly at 0200 (2:00 a.m.) the othe CNA stated she had HA + stopped working contined to do checks . Around 6am care were being done on 2 other residents + cleaning of a room needed done . at this time [resident #4] started to yell out. Did walk down the hall and see Resident on the floor on matt. It was asked to other CNA (NF11) what to do and aid stated 'I can't do anything the day shift will be in. Continued to get people up as another Resident needed to be changed + gotten up for day. Employee stated she didn't feel comfortable with resident because he would yell + call CNA names and belittle her. Didn't think to tell the nurse. [sic] (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of NF10's employee personnel file showed NF10 was terminated on 3/13/25. NF10 received abuse, neglect, and resident rights training on 2/3/25 from NF3. Review of NF11's witness statement, written by NF4, dated 3/6/25, showed: Resident was checked and changed at 2030 (8:30 p.m.) + linen change he was taking off pullup up and peeing everywhere . Resident 0145 (1:45 a.m.) checked was sleeping brief wet + again took brief off + was peeing on bed lining changed and care done . Did no cares from 0400 (4:00 a.m.) to 0700 (7:00 a.m.) . Did not hear Resident from 0400 (4:00 a.m.) - till 0630 (6:30 a.m.) . [sic] Review of NF11's employee personnel file showed NF11 was terminated on 3/11/25 due to neglect. NF11 had a previous performance review on 12/12/24 which showed, Ensures residents are well cared for and look good when working in the SCU. NF11 had a discipline note signed by NF4 which showed a termination date of 3/11/25 with supporting information which showed, Cameras reviewed and CNA did not do any cares from 0200 (2:00 a.m.) to 0700 (7:00 a.m.) causing neglect to residents. Review of a facility document titled, Abuse and Neglect - Clinical Protocol, dated Quarter 3, 2018, showed: . 2. 'Neglect,' as defined at Section 483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.' . 5. Along with staff and management, the physician will help identify situations that might constitute or could be construed as neglect; for example . inattention to . resident wishes, inappropriate management of problematic behavior, recurrent failure to provide incontinence care .

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a resident with dementia from eloping from the facility through the front entrance doors, leaving the facility property without supervision and accessing a public road, for 1 (#1) of 6 subsampled residents at risk for elopement. The resident sustained lacerations to his forehead after falling during the elopement. Findings include: Review of a facility reported incident, submitted to the State Survey Agency, dated 5/3/25 at 1:45 p.m., showed resident #1 was found outside of the facility by the police and was transported to the hospital for an evaluation. During an interview on 6/16/25 at 4:18 p.m., NF2 stated she received a call from the facility on 5/3/25. NF2 stated resident #1 was found at an apartment complex, on the ground, by a passerby who called the police and ambulance. NF2 stated resident #1 sustained a head laceration and was admitted to the hospital for observation. A call was placed to the police department on 6/18/25 at 12:40 p.m., and the police chief stated NF5 was the only staff member who could release the report for resident #1, regarding the incident which occurred on 5/3/25. The police chief stated NF5 would not be in the office until 6/19/25. During an interview, on 6/18/25 at 12:55 p.m., staff member F stated on 5/3/25 at 11:30 a.m., he received a call from the police department stating a resident was located near an apartment complex. Staff member F stated the facility did a head count of all residents and realized resident #1 was missing from the facility. Staff member F stated he responded to the location where resident #1 was found and it appeared the resident had a laceration to his head. Staff member F stated the resident was transported by ambulance to the hospital for an evaluation. Staff member F stated NF6 responded to the front door alarm when resident #1 exited, but did not see any residents when he (NF6) scanned the outside perimeter of the facility. Staff member F stated he was not sure why NF6 did not do a head count of the residents in the facility after the alarm went off. During an interview, on 6/19/25 at 8:37 a.m., NF6 stated he responded to the front door alarm on 5/3/25 at 10:08 a.m. NF6 stated when he responded to the alarm, he exited the front door of the facility, and scanned the perimeter of the building. NF6 stated he did not see any residents outside. NF6 stated he received orientation when he started his employment, but never read the facility elopement policy. NF6 stated during his orientation, NF4 stated, You know all this, you can just sign the paper. Calls were placed to NF5 on 6/19/25 at 8:00 a.m. and 12:38 p.m., with voicemails left on both occasions requesting a return call regarding resident #1's incident on 5/3/25. No return call was received from NF5 by the end of the survey. Review of a facility document titled, Timeline for elopement of (resident #1), dated, 5/3/25, showed: - 10:06 a.m. (resident #1) exits the front doors and walks around the front of the building very quickly. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- 10:08 a.m. staff member, (NF6), does exit the front doors, responding to the alarm, stands on the front patio and scans the immediate area and remains outside looking around the area for about 30 seconds and returns inside. - Camera footage reviewed by (NF3) 5/3/25 at noon. Review of resident #1's EHR showed resident #1 was admitted to the facility on [DATE] for skilled nursing services with a diagnosis of dementia. Review of resident #1's elopement risk assessment dated , 4/7/25, showed the resident was at risk for elopement with a score of 6. Review of resident #1's wander assessment dated , 4/7/25, showed the resident was at moderate risk for wandering with a score of 10. Review of resident #1's nursing progress notes showed the following: - On 4/7/25 at 5:45 p.m., resident #1 was found in another resident's bathroom. Resident #1 required redirection by the nurse back to his room. - On 4/7/25 at 8:00 p.m., a wander guard was placed on resident #1's right ankle. - On 4/16/25 at 12:40 p.m., resident #1 eloped from the front doors of the facility. The nurse responded to the alarm. Resident #1 resisted staff redirection and continued to walk away from the facility accompanied by the nurse. Resident #1 was eventually redirected by the nurse back into the facility. The resident was not unattended during the attempted elopement. - On 4/17/25 at 8:03 p.m., resident #1 was found on the service hallway setting off the door alarm. Resident #1 was redirected by staff back to the main part of the facility from the service hall to the D hall. - On 5/3/25 at 1:46 p.m., a call was received from the police department at 11:28 a.m. Resident #1 was found outside the facility at an apartment complex. Resident #1 was found by the nurse seated on a bench accompanied by two police. Resident #1 had an abrasion on his left forehead and appeared to guard his left arm. Emergency medical services were called, and the resident was taken to the emergency department for an evaluation. A written request for resident #1's 5/3/25 police report was made to the facility on 6/16/25 and 6/17/25. No documentation was received from the facility by the end of the survey. Review of the facility document titled, Process for triggered wanderguard alarm, undated, showed: 1. All staff will respond any door that is alarming. 2. Staff will immediately assess why the door is alarming. 3. Staff will walk the parameter of the area to identify if a resident has left the building. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. If there is not an identified reason the door is alarming, a CODE GRAY must be announced on the overhead pager and all staff must respond to the C/D nurses station. 5. A full head count must be completed by staff. The A/B nurse will be responsible for assigning staff which residents to check on and/or locations to check. Staff will report completed assignments to the A/B nurse. 6. The administrator and Director of Nursing/on-call nurse, must be notified of any elopement. 7. If a head count has been completed and a resident is not located, law enforcement will be notified. [sic]

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure nursing staff were adequately trained and had the knowledge necessary to fulfill the nursing role related to the facility's elopement policy. The failure resulted in a resident eloping from the facility unattended, for 1 (#1) of 6 subsampled residents at risk for elopement. Findings include: During an interview, on 6/18/25 at 12:55 p.m., staff member F stated on 5/3/25 at 11:30 a.m., he received a call from the police department stating a resident was located near an apartment complex. Staff member F stated the facility did a head count of all residents and realized resident #1 was missing from the facility. Staff member F stated he did not hear the alarm sound the day (5/3/25) resident #1 eloped. Staff member F stated NF6 responded to the door alarm, but did not see any residents when he scanned the outside perimeter of the facility. Staff member F stated he was not sure why NF6 did not do a head count of facility residents after the alarm sounded. During an interview, on 6/19/25 at 8:37 a.m., NF6 stated he responded to the front door alarm on 5/3/25 at 10:08 a.m., the day of #1's elopement. NF6 stated he was not aware he was to do a head count of residents in the facility when a door alarm sounded. NF6 stated he received orientation when he started his employment, but never read the facility elopement policy. Review of resident #1's nursing progress note, dated 5/3/25 at 1:46 p.m., a call was received from the police department on 5/3/25 at 11:28 a.m., resident #1 was found outside the facility at an apartment complex. Review of a facility document titled, Timeline for elopement of (resident #1), dated, 5/3/25, showed the resident exited the facility out the front doors and walked around the building quickly. In under two minutes, staff member NF6 exited the front doors to check why the alarm sounded. The employee scanned the area, and returned inside, not noticing the resident. Review of the facility document titled, Process for triggered wanderguard alarm, undated, showed: . 4. If there is not an identified reason the door is alarming, a CODE GRAY must be announced on the overhead pager and all staff must respond . 5. A full head count must be completed by staff . 7. If a head count has been completed and a resident is not located, law enforcement will be notified. [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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a system of communicable disease surveillance was maintained for tracking purposes and to protect residents from further transmission of infection, during an influenza outbreak in the facility, with 2 (#s 7 and 10) of 5 sampled residents, remaining in the same room after one tested positive for the flu and the other was not tested. Findings include: During an interview on [DATE] at 8:55 a.m., staff member L stated residents and staff members began to get sick very quickly during the influenza outbreak (week of [DATE]). Staff member L stated resident #7 and resident #10 were roommates who had been ill during that time. Staff member L stated NF4 was the infection preventionist. Staff member L stated both NF3 and NF4 were out of the facility during the time of the outbreak, so she coordinated the response between the facility and State health department. Staff member L stated there were discrepancies in NF4's data that had been documented, including dates of when residents were tested and when residents were deceased . During an interview on [DATE] at 4:56 p.m., NF3 stated staff and residents were sick during the time an influenza outbreak occurred (week of [DATE]). NF3 stated staff member L had email coordination with the State health department during the time she (NF3) and NF4 were out of the facility [DATE] through [DATE]. NF3 stated NF4 stated to her information for the influenza outbreak was kept in the facility infection control binder. NF3 stated NF4 communicated that she (NF4) had reported the outbreak to the State health department. NF3 stated NF4 reported the infection control binder would have a list of residents tested, and symptomatic residents. NF3 stated resident #10's roommate at the time (resident #7) was positive for the flu (week of [DATE]). NF3 stated resident #10 was not tested for flu. NF3 stated resident #7 remained in the same room as resident #10 after testing positive for flu. NF3 stated, We knew we should have moved people, but we didn't want to mix them with people who weren't symptomatic. During an interview on [DATE] at 11:32 a.m., NF4 stated that four residents had respiratory symptoms, and the facility began testing for influenza. NF4 stated she was out of the facility during the influenza outbreak. NF4 stated staff members helping with infection control coverage in her absence were the facility's previous ADON, and the MDS nurse. NF4 stated the previous ADON was supposed to keep a list and document residents for surveillance. NF4 stated when she returned to the facility, she was trying to backtrack to get everything done. NF4 stated she did not know where the list was of who was isolated or who was not. NF4 stated she documented dates incorrectly, when she was trying to work outside of the facility. NF4 stated she did not have the tracking and trending completed in the infection control binder for February (2025). NF4 stated she did not complete the infection mapping for February (2025), and did not receive the infection mapping from the previous ADON. 1. Review of resident #7's physician progress notes, dated [DATE], showed medical problems including, Debility, Atrial fibrillation . CHF, Cognitive impairment . There was not a documented date in resident #7's electronic medical record to show when he tested positive for influenza. There was no documentation showing the facility moved resident #7 to a different room when he tested positive for influenza. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of resident #10's medical diagnosis report, dated [DATE], showed a primary diagnosis of Chronic Obstructive Pulmonary Disease with (acute) Lower Respiratory Infection, a secondary diagnosis of Type 2 Diabetes Mellitus, and unspecified Atrial Fibrillation. Resident #10's primary diagnosis placed him at higher risk for respiratory complications. There was no documentation of testing resident #10 for influenza. There was no documentation of moving resident #10 when his roommate (resident #7) tested positive for influenza. Review of a facility infection control map dated, Feb/2025, showed no resident rooms with any identified cases for influenza. A written request was made to the facility on [DATE] for the February 2025 infection control log. No documentation was received by the end of the survey. Review of a facility document, untitled and undated, showed a list with the following: - Two residents testing positive on [DATE], - Nine residents testing positive on [DATE] and, - Four residents testing positive on [DATE]. The list did not show documentation of resident #7 and resident #10 being tested on 2/15, 2/16, or [DATE]. Review of a facility policy titled, Infection Prevention and Control Program, revised [DATE], showed: . 7. Surveillance . b. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics . e. The medical staff will help the facility comply with pertinent state and local regulations concerning the reporting and management of those with reportable communicable diseases . Review of a facility policy titled, Isolation - Categories of Transmission-Based Precautions, last dated Quarter 3, 2018, showed: . Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection . e. Influenza . 3. Resident Placement a. Place the resident in a private room if possible. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. When a private room is not available, residents with the same infection with the same microorganism but with no other infection may be cohorted .