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	02/13/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on interview and record review, the facility failed to ensure POLST forms were completed accurately in the electronic medical records, for 2 (#s 45 and 109) of 17 sampled residents. Findings include: A review of resident #45 and #109's electronic medical records, showed POLST forms with no date of the signature, which is required on the form for validity and the physician order. The dates should have been filled in next to the provider's signature. Resident #45's POLST form showed a checkmark next to, Yes CPR, and Full Treatment. Resident #109's POLST form showed a checkmark next to, No CPR, and Selective Treatment. During an interview on [DATE] at 8:29 a.m., staff member A stated POLST forms are reviewed by nursing staff members during a resident's admission. Staff member A stated POLST forms were reviewed annually during a resident's care conferences but not during all quarterly care conferences. Staff member A stated there is no specific nurse overseeing or reviewing POLST form completion for new admissions, it is usually the admitting nurse who reviews it. Staff member A stated the provider who completed the POLST form reviews the form. A request was made on [DATE] at 9:50 a.m., for a hard copy document of resident #45 and resident 109's POLST forms. The facility provided a hard copy document of resident #45's POLST form which still showed a missing date next to the provider's signature. Review of a facility document titled, Advance Directive Policy, included in the Admission Packet, showed: . If you do have an advance directive, we will ask for a copy to put in your medical record and give to your physician. . We will comply with the directions given in your advance directive in accordance with applicable laws, your physician's orders . Review of a facility policy, titled, Advance Directives, revised [DATE], showed: (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: 275144	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Physician Orders for Life-Sustaining Treatment (or POLST) . form - a form designed to improve patient care by creating a portable medical order form that records patients treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency . . Prior to or upon admission of a resident, the social services director or designee inquires . about the existence of any written advance directives . if the resident . has executed one or more advance directive(s) . copies of these are obtained and maintained in the same section of the residents medical record . . The director of nursing services (DNS) or designee notifies the attending physician of advance directives . so that appropriate orders can be documented in the residents medical record and plan of care . The residents wishes are communicated . in care planning meetings .

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51111 Based on observation, interview, and record review, the facility failed to provide a clean, sanitary, and homelike environment for 2 (#s 45 and 109) of 17 sampled residents. Findings include: During an observation on 2/11/25 at 9:35 a.m., resident #45's bathroom floor had color stains around the edges of the toilet, towards the wall, behind the toilet. There was dark brown crusted debris along the linings of the walls to the left of, in front of, and behind the toilet. The bathroom had caked and dried dark yellow substance on the floor which appeared to be urine, and there was a strong odor of urine. During an observation on 2/11/25 at 2:29 p.m., resident #45's bathroom floor still had colored stains around the edges of the toilet, towards the wall, behind the toilet. There was dark brown crusted debris along the linings of the walls to the left of, in front of, and behind the toilet. There was still a strong odor of urine. During an observation on 2/11/25 at 2:59 p.m., along the bottom of resident #109's wall below the heater, close to the sink area, was a peeling hole in the wall with paint cracking and lifting up from the edges of the hole. During an interview on 2/12/25 at 3:29 p.m., staff member G stated housekeeping staff had assignments to clean resident rooms daily, which included cleaning in the bathrooms. Staff member G stated housekeeping completes a deep cleaning of resident rooms and bathrooms when a resident is discharged and before a new admission arrives. During an observation on 2/13/25 at 9:12 a.m., resident #45's bathroom had a caked and crusted dark yellow urine stain along the floor on the right side of the toilet. A strong odor of urine was present in the bathroom. There was dark brown crusted debris along the linings of the walls to the left of, in front of, and behind the toilet. During an interview on 2/13/25 at 9:15 a.m., staff member K stated, I think I know which bathroom you want to look at. Staff member K stated she had been working in the facility for three weeks. Staff member K stated she had not deep cleaned resident #45's bathroom and had not gone in there to clean that day. Staff member K stated the crust along the edges of the wall to the floor had been there since she started. Staff member K stated she cleans resident rooms and bathrooms everyday as an assignment. During an interview on 2/13/25 at 9:25 a.m., resident #109 stated he was not told what happened to make the hole in the wall below the heater. He stated it was like that since he got to the facility about two weeks ago. He stated he thought it's gotten bigger since he first arrived. He stated no staff from the facility had tried to cover or fix the hole since he had been in the room. Review of a facility policy titled, Cleaning and Disinfecting Resident' Rooms, dated April 2013, showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled . Clean spills of . body fluids as outlined .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48262 Based on interview and record review, the facility failed to ensure resident PASRRs (Pre-Admission Screening and Resident Reviews) were completed and accurate for 3 (#s 28, 35, and 38) of 17 sampled residents. Findings include: 1. Review of resident #28's EMR, accessed 2/12/25, showed the resident was admitted to the facility on [DATE]. The resident's diagnoses included, . Dementia other disease class with behavioral disturbance, anxiety disorder unspecified, mood disorder known psychological condition unspecified, major depressive disorder single episode unspecified, post-traumatic stress disorder chronic, and suicidal ideations . Review of resident #28's PASRR, dated 06/29/22, showed: Categorical approval - convalescent stay, if he (#28) stays past 29 days a new L 1 (level one) must be submitted . [sic] During an interview on 2/12/25 at 4:00 p.m., staff member A stated resident #28 had a PASRR completed on 6/29/22 and was not aware it was a categorical approval. Staff member A stated a new PASRR Level One would be completed on resident #28. 51111 2. a. Review of resident #35's medication administration record, dated January 2025, showed medical conditions including: .state of emotional shock and stress, unspecified; hallucinations, unspecified; mood disorder due to known physiological condition, unspecified; depression, unspecified; posttraumatic stress disorder, unspecified; cognitive communication deficit . b. Review of resident #38's electronic medical record showed diagnoses of cognitive communication deficit; major depressive disorder, recurrent, unspecified; other specified persistent mood disorders; violent behavior; post-traumatic stress disorder, chronic . A request was made to the facility on [DATE] at 9:50 a.m., for PASARR Level One forms for resident #35 and #38. No forms were provided from the facility by the end of the survey. During an interview on 2/13/25 at 11:19 a.m., staff member A stated she could not find PASARR Level One forms for resident #35 and #38. Staff member A stated she would have been the staff member to have a PASARR started for resident #35 and #38 due to their diagnoses. Staff member A stated she did not know why she did not do that for resident #35 or resident #38 to have them done. Review of pages 8 and 9 of a facility document titled, Facility Assessment, updated 7/23/24, showed: .1.3b Cognitive Disabilities: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. PASSR completed to determine other accommodations. The appropriate assessments are completed to ensure resident is appropriately placed . [sic]

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on observation, interview, and record review, the facility failed to create a baseline care plan with pertinent condition specific information to address resident needs, within the 48-hour timeline following a resident's admission, for 1 (#109) of 17 sampled residents. Findings include: During an observation on 2/11/25 at 4:34 p.m., resident #109 was sleeping in bed and wearing a nasal cannula, connected to an oxygen concentrator, turned on to two liters of oxygen. During an observation on 2/12/25 at 9:59 a.m., resident #109 was sleeping in his bed and wearing a nasal cannula, connected to an oxygen concentrator, turned on to two liters of oxygen. Review of resident #109's electronic medical record showed resident #109 was admitted to the facility on [DATE]. Review of resident #109's treatment administration record, dated February 2025, showed the oxygen at 2 liters per nasal cannula was ordered to start on 1/25/25 at 6:00 a.m. Review of resident #109's care plan, showed an initiation date of 2/1/25 for resident #109 to receive supplemental oxygen for [NAME]/pulmonary health/respiratory condition r/t COPD Oxygen per nasal cannula at 2 Liters/Min . [sic] During an interview on 2/13/25 at 12:02 p.m., staff member C stated a resident's baseline care plan is started when the UDA (user defined assessment) is completed by the admitting nurse. Staff member C stated some parts of documentation from the electronic medical record, which are pulled into the baseline care plan, included information on medications, physical functioning, pain, and skin. Staff member C stated she did not know if oxygen treatment pulled over into the baseline care plan. Staff member C stated she was not sure how to find out where the baseline care plan is done and she is not sure how to tell what is on the baseline care plan. Review of a facility policy titled, Care Planning - Interdisciplinary Team, revised March 2022, showed: The interdisciplinary team is responsible for the development of resident care plans. 1. Resident care plans are developed according to the time frames and criteria established by S483.21. Review of a facility policy titled, Care Plans - Baseline, revised March 2022, showed: . A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . includes instructions needed to provide effective, person-centered care of the resident . and must include the minimum healthcare information necessary to properly care for the resident . The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed .

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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. 14005 Based on observation, interview, and record review, the facility failed to update resident care plans in a timely manner for 1 (#33) of 17 sampled residents. Findings include: Review of resident #33's weight report, dated 9/11/24 and 10/7/24, showed resident #33's weight went from 143 pounds down to 131 pounds. This was a 12 pound or 8.39 percent weight loss in 26 days. During an observation on 2/11/25 at 10:42 a.m., resident #33 was observed to rapidly get out of the chair and pacing in his room on three occasions during the 10-minute interview. Resident #33 said his skin condition burned, itched, and bothered him. Resident #33 said he can't sit still because of his skin irritation. Resident #33 said he had lost weight, but he had atrial fibrillation and shouldn't gain any weight. Review of resident #33's comprehensive care plan, updated on 9/20/24 showed, a potential for the presence of altered nutrition needs. The facility did not identify or update the care plan to include interventions to stop the weight loss that occurred in October 2024. Review of residents #33's Nurse Practitioner note, written 10/21/24, showed, resident #33 had been focusing on his rash and had not been eating or drinking well. Review of resident #33's physician orders, dated 1/10/25, showed, Med Pass 2.0 was ordered for the resident to receive 120 milliliters twice a day. Review of resident #33's comprehensive care plan showed, the care plan was not updated with weight loss interventions until 1/26/24. Review of resident #33's comprehensive care plan showed, no dietary interventions for increasing food intake when the resident was hyper focused on his skin, pacing, and was not eating well. During an interview on 2/13/25 at 11:01 a.m., staff member C said each discipline is responsible for updating their own care plans. Dietary would update nutrition, the MDS nurse would update the nursing section. Staff member C said the care plans got updated after the MDS (minimum data set) is opened and the assessment reference date is added. For changes and updates that need added to the care plan, staff member C said the team hears different stuff at the interdisciplinary team meeting. The areas of concern are discussed, and the care plans are updated as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 14005 Based on interview and record review, the facility failed to assess a resident for safety with smoking, failed to monitor the resident's location when smoking and ensure the resident signed out of the facility when smoking, and failed to follow and adhere to the facility policy related to resident smoking. These failures occurred over an extended period of time, for multiple shifts and days, and multiple staff failed to adhere to the policy, for 1 (#39) of 17 sampled residents. Findings include: During an interview on 2/10/25 at 3:11 p.m., resident #39 said he goes outside to smoke four to five times a day. He said he must go off the facility property to smoke because there is a no smoking policy. Resident #39 said he had a warm coat and gloves for standing outside. Resident #39 said there is nowhere to go to be sheltered from the wind and cold weather when out smoking. Resident #39 said he knows that he is supposed to sign out when he goes out and smokes, however he said he doesn't sign out. Resident #39 was unable to explain why he did not sign out. Resident #39 said he had never gotten locked out after hours because of smoking. Resident #39 said there is a button, and when he rings for the staff, they come quickly and let him in. Review of facility document titled Smoking Policy - Residents, dated 10/2023, showed: . - Smoking is only permitted in designated resident smoking areas, which are located outside of the building. - The attending physician will be consulted with to determine if safety restrictions need placed on the resident's smoking privileges. - Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable lighters are permitted. All other forms of lighters, including matches, are prohibited. - If the facility policy changes to one that prohibits smoking (including electronic cigarettes, residents who are currently allowed to smoke will be provided an area to smoke which maintains the quality of life and safety for smoking residents, while considering the health and well-being of non-smoking residents. During an interview on 2/11/25 at 2:00 p.m., staff members A and B discussed the smoking policies and facility expectations. Staff member A said the facility went smoke free sometime in the summer of 2024. The residents that were smoking at that time were grand-fathered in. The residents are not allowed to keep their smoking paraphernalia with them. The facility had provided a metal container that is weatherproof, and the residents keep their cigarettes in there. Staff member A and B said the residents were expected to sign out when they go outside to smoke as they are going off the property. Staff member A said there was not a shelter of any kind for the residents. Staff member A said the facility didn't build anything for shelter as the smoking took place off the facility property. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility document titled, Release of Responsibility for Leave of Absence, for dates 1/27/25 through 2/10/25, showed resident #39 had not signed out at all to go smoke during that time, even though resident #39 stated he goes outside four or five times every day to smoke. During an interview on 2/13/25 at 8:14 a.m., staff member B said resident #39 knows to sign out when he goes out to smoke. Staff member B said she would not be surprised that resident #39 had not been signing out. Staff member B said resident #39 knows he is to sign out, he says he will, and then obviously he does not sign out. Staff member A said the smokers that are outside after dark were given reflectors to put on their coats for increased safety. Review of resident #39's, Smoking Evaluation, dated 9/03/24, completed at 5:57 p.m., showed, the assessment as incomplete, and resident #39's ability to safely smoke was not assessed. Resident #39 was not assessed for cognitive issues and confusion related to ability to smoke. Those cognition questions were left unanswered. Visual acuity and dexterity problems were not assessed and answered. Questions to resident #39's ability to light and extinguish his own cigarettes were not answered. Review of resident #39's Nurse Practitioner notes showed: - 12/18/24, resident #39 was an active smoker, however smoking safety had not been addressed. - 1/14/25, smoking was mentioned, but smoking safety was not addressed. - 1/21/25, #39 was a smoker and had no interest in smoking cessation, but smoking safety had not been addressed. - 1/28/25, the resident smoked but smoking safety had not been assessed. Review of resident #39 physician notes, dated 11/23/24, showed the physician identified resident #39 smoked. There was no documentation to show resident #39 was safe to smoke.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48262 Based on interview and record review, the facility failed to have an RN working at least eight consecutive hours a day, per the twenty-four-hour period, seven days per week. This deficient practice had the potential to affect all residents who received nursing services and when an RN was needed, one was not immediately available. Findings include: Record review of the July and September 2024 schedule for licensed nursing, showed the following dates did not have eight consecutive hours of RN coverage documented in a twenty-four-hour period: - 7/6/24, 7/7/24, 7/13/24, 7/14/24, 07/20/24, and 9/1/24. During an interview on 2/13/25 at 11:30 a.m., staff member A reviewed and compared the facility's nursing schedule with the [NAME] payroll-based journal report for the period of July 2024 to September 2024. Staff member A stated on the [NAME] report there were no RN hours within a twenty-four-hour period on the dates triggered for No RN hours. Staff member A stated the facility had one RN out with short notice. Staff member A stated the director of nursing had been on call but did not work eight consecutive hours. Staff member A stated the facility had not applied for a staffing waiver.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51111 Based on observation, interview, and record review, the facility failed to ensure staff prepared food in a sanitary manner; failed to ensure freezer equipment was maintained and that food items in the walk-in refrigerator and freezer were covered, labeled, and dated. This failure increased the risk of food borne illnesses, and may negatively affect all residents receiving services from the dietary department. Findings include: During an observation on 2/10/25 at 12:44 p.m., staff member H was working in a food preparation area, with a grown mustache and beard, which was not covered with a beard net. Staff member H failed to uphold infection control measures related to food safety. During an observation on 2/10/25 at 12:47 p.m., the walk-in freezer had a box with a plastic bag of omelets inside, which was left partially open, and not dated. There was an opened plastic bag holding the undated pork sausages. During an observation and interview, on 2/10/25 at 12:48 p.m., the walk-in freezer had large chunks of ice buildup under one of the compressor fans on the top shelf. There was a silver tray placed underneath the fan, to hold the ice chunks. The shelves below had boxes of food placed directly below the area with the tray holding the ice chunks. Two of the boxes of food had ice chunks stuck to the backs of the boxes. Staff member G stated there was a request put in for a new fan, and they were waiting for it to be purchased. Staff member G stated she would ask staff to chip the ice chunks away, and she usually had staff clear the tray area of the ice chunks. During an observation on 2/10/25 at 12:58 p.m., the walk-in refrigerator had two heads of lettuce, not covered, placed in a colander, which was in a box on the shelf. During an observation on 2/12/25 at 11:43 a.m., staff member H was cutting meat in the cold preparation food area, with a grown mustache and beard, which was not covered by a beard net. Staff member H had several skin tears on his right forearm, which weren't covered. Staff member H had several scabbed over skin tears on his left forearm which weren't covered. During an observation on 2/12/25 at 11:47 a.m., the walk-in freezer still had large chunks of ice buildup under one of the compressor fans, on the top shelf. A silver tray was directly underneath the fan on the shelf, to hold the ice chunks. The shelves below had boxes of food placed directly under the fan and tray holding the ice chunks. Two of the boxes of food had ice chunks stuck on the backs of the boxes. During an interview on 2/12/25 at 12:48 p.m., staff member H stated he completed ServSafe training three weeks ago. Staff member H stated someone called off that day, and said, So we are short-handed and scrambling. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/12/25 at 3:16 p.m., staff member G stated she thought the facility had a policy for staff to wear beard nets if they had facial hair that grew out longer than a half an inch. Staff member G stated she asked staff to chip away ice chunks that formed on the silver tray under one of the walk-in freezer's compressor fans. During an observation on 2/13/25 at 9:35 a.m., the walk-in refrigerator still had the two heads of lettuce, uncovered, placed in a colander, in a box on a shelf. Review of a facility policy titled, Dress Code and Personal Hygiene, dated May 2019, showed: . Arranging hair so that it does not interfere with work assignments . depending on . work area, an employee with long hair may require a hair net . Facial hair should be trimmed close to the face and kept clean . Review of a facility policy titled, Food Receiving and Storage, dated November 2022, showed: . Food services, or other designated staff, maintain clean and temperature/humidity appropriate food storage areas at all times . All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) . refrigerated foods are stored in such a way that promotes adequate air circulation around food storage containers . Wrappers of frozen foods must stay intact until thawing . [sic]