STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275153	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Awe Kualawaache Care Center	10131 S Heritage Rd Crow Agency, MT 59022

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 0600 Level of Harm - Minimal harm or potential for 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. 46400 Based on observation, interview, and record review, the facility failed to prevent resident abuse in the form of a physical altercation with a staff member for 1 (#2) of 4 residents sampled. Findings include: Review of resident #2's nursing progress notes, dated 7/22/24, showed, Resident and her assigned one on one CNA in the door way to the dining room. CNA has residents hands behind her back pulling on her in an aggressive manner. Holler for CNA and security to help. CNA pulled resident to the floor with her hands still behind her back . [sic] During an interview on 7/29/24 at 1:20 p.m., staff member A stated when the staff to resident altercation had been reported to her, she came to the facility to review the security footage and began investigating the incident. Staff member N was removed from the shift, and later terminated. Staff member A stated through interviews the facility learned staff member N was easily angered and had been a bully. During an observation on 7/29/24 at 2:45 p.m., the security camera footage, dated 7/22/24, showed resident #2 walking into the dining room with her walker. Staff member N was the assigned 1:1 following the resident at a distance. Resident #2 turned and left the dining room, aggressively pushing her walker towards staff member N. Staff member N grabbed the resident by her arms, turned her around with her arms behind her back, and pulled her to the ground, despite other staff coming to help de-escalate the situation.

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 46400 Based on interview and record review, the facility failed to assess for the root cause or triggers of behavioral outbursts for 1 (#2); and failed to provide the behavioral health services outlined in a PASRR Level II for 1 (#4) of 4 sampled residents. Findings include: 1. Review of resident #2's nursing progress notes, dated 6/29/24 - 7/30/24, showed the resident had been assigned a 1:1 sitter after a pattern of agitation and aggression towards other residents and staff including: - 6/29/24 Assaulting another resident and being sent to [Clinic Name 2] emergently for a psychiatric evaluation. - 7/1/24 Pacing and agitation resulting in a phone call to the physician for a one-time medication order. - 7/2/24 Cursing and yelling at her 1:1. - 7/11/24 Kicking at another resident seated in her recliner. - 7/22/24 Charging and punching her 1:1. During an interview on 7/30/24 at 9:11 a.m., staff member A stated there were no root cause assessments done to identify trends or triggers related to resident #2's incidents. Staff member A stated it did not appear anyone was looking at the documentation on the 1:1 sitter sheet to determine if there were patterns associated with resident #2's behaviors. During an interview on 7/30/24 at 10:00 a.m., staff member J stated the facility had been told by [outside behavioral health clinic 2] to not send a referral to have resident #2 seen, but to send her through the E.R during a crisis. Staff member J stated this was difficult because the drive to this clinic was an hour, and the resident was calm by the time she arrived at the clinic. Staff member J stated the facility had sent out many referrals and requests for new placements with every place declining to take resident #2, due to her behaviors. 2. Review of resident #4's PASRR Level II, dated 6/2/22, showed the resident had a history of schizophrenia and institutionalization that required the specialized services of Outpatient Mental Health. Review of resident #4's EMR failed to show any documentation the resident was receiving or refusing any form of outpatient mental health services. During an interview on 7/30/24 at 12:00 p.m., staff member B stated it was a near weekly conversation with [outside clinic 1] to have the residents at the facility seen for behavioral health services. Staff member B stated [outside clinic 1] was the only provider in the area, and had been difficult to work with. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the exit conference on 7/30/24 at 1:00 p.m., staff member A stated the intention was to send the requested behavioral health documentation to the State Survey Agency. No documentation was received.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46400 Based on interview and record review, the facility failed to ensure prn psychotropic drugs were limited to 14 days or had documented rationale for extended prn usage; and failed to ensure prn anti-psychotic drugs were limited to 14 days and not renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication for 1 (#2) of 4 sampled residents. Findings include: Review of resident #2's MAR, dated July 2024, showed the resident had prn orders for: 1. Ativan 1mg give 1 tablet by mouth every 8 hours as needed for agitation. There was a start date of 7/1/24. The resident had received this dose seven times for the month of July. There was no physician documentation detailing the resident's need for continued prn dosing of this medication. There was no stop date listed. 2. Olanzapine 2.5mg give 2.5mg by mouth every 6 hours as needed for depression. There was a start date of 7/1/24. The resident had received this dose twice for the month of July. There was no physician documentation of an evaluation to extend the prn dosage period of this medication. There was no stop date listed. During an interview on 7/30/24 at 12:00 p.m., staff member B stated the physician was at the facility once per month, otherwise available by phone. They did not have an onsite physician who could re-evaluate residents after the 14-day prn period for antipsychotics was met. Staff member B stated pharmacy did the monthly reviews to catch stop dates, but had not yet done the reviews for the month of July 2024.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 48261 Based on interviews and record review, the facility failed to review and update the facility assessment to include the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population for residents with behavioral health needs. This practice had the potential to affect residents with behavioral health needs admitted to the facility. Findings include: During an interview on 7/29/24 at 3:58 p.m., staff member H stated resident #2 required a one-to-one sitter related to behaviors. Staff member H stated the facility was waiting for a psychological evaluation to be done. Staff member H stated staff member J was responsible for setting up the psychological evaluations. Staff member H stated, [Resident #2] deserves to be in a place that is more equipped to take care of behavior patients. I'm afraid to say it, but if we don't get her somewhere, it's (staff to resident abuse) going to happen again. We are not equipped to care for her. During an interview on 7/30/24 at 9:06 a.m., staff member J stated, We are not equipped to take care of [resident #2]. I don't know why the facility assessment says we can take behavior patients, we really shouldn't. I'm new and didn't know anything about facility assessments until yesterday when it was requested (by surveyors). During an interview on 7/30/24 at 10:26 a.m., staff member E stated there were seven residents with aggressive behaviors on the unit that she was aware of. Staff member E reported the following behaviors included: hitting, kicking, pinching, yelling, throwing things, and cussing. Staff member E stated, They (CNAs) really don't have the skills to care for these behaviors. I don't even know how I would handle some of them in the moment. Review of the facility provided, Facility Assessment, dated 12/13/22, reflected: -Part 2: Services and Care We Offer Based on our Residents' Needs -Mental health and behavior: manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 48261 Based on observation, interview and record review, the facility failed to provide behavioral health training for staff; consistent with the needs of the residents in the facility for 2 (#s 2 and 3) of 4 sampled residents. Findings include: During an observation and interview on 7/29/24 at 1:17 p.m., resident #2 was lying in bed diagonally, watching the television. Staff member C was sitting in a chair next to resident #2's bed looking at a personal cell phone. Staff member C stated she was the sitter for resident #2. Staff member C stated she was to document every 15 minutes what resident #2 was doing, and follow her if she left her room. Staff member C stated she was not aware of any behaviors resident #2 had in the past, and no one told her what she should do if resident #2 had behaviors. Staff member C stated she, . would try to go find the Director of Nursing if something happened. Staff member C stated she had not been trained on how to handle behaviors. During an interview on 7/29/24 at 1:25 p.m., staff member D stated she did not know about the care plan or the interventions for resident #2's behaviors. During an interview on 7/29/24 at 1:32 p.m., staff member E stated resident #2 was very fast and strong. Staff member E stated resident #2 had a sitter, and all the sitters could do was stay with her. Staff member E stated the facility had medication for resident #2's behaviors, and the only trigger she was aware of was if someone sat in her favorite chair in the common area. Staff member E stated she did not know if resident #2 had other triggers and stated resident #2 frequently had behaviors for no reason. Staff member E stated resident #2 had frequent outbursts of aggressive behavior toward staff and residents. Staff member E did not know what the care plan interventions were other than a sitter and medication. Staff member E stated, Truthfully, I don't know what I'd do when she gets aggressive, attacking people. Staff member C stated she had not been trained on how to handle behaviors. During an interview on 7/29/24 at 1:41 p.m., staff member F stated resident #2 was quick. Staff member F stated, I usually tell her, 'Don't do that' and try to get her back in her room. Staff member F stated she had not had training on managing behaviors specifically, and did not know what interventions were on resident #2's care plan. During an interview on 7/29/24 at 3:27 p.m., staff member G stated if a resident were to become aggressive toward her, she would yell for a nurse, and they would take care of it. We (staff) were told not to fight back, just go get a nurse. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/29/24 at 3:58 p.m., staff member H stated resident #2 required a one-to-one sitter related to behaviors. Staff member H stated, [Resident #2] deserves to be in a place that is more equipped to take care of behavior patients. I'm afraid to say it, but if we don't get her somewhere, it's (staff to resident abuse) going to happen again. We are not equipped to care for her. Staff member H stated the staff at the facility were not trained to care for the residents behaviors. Staff member H stated he had told staff to call for him when the behaviors occur so he could help them, but if he was not available the only thing the staff could do was to use the call light for a nurse to come help. During an observation and interview on 7/30/24 at 8:15 a.m., resident #2 finished her breakfast in the dining room and immediately returned to her room. Staff member I was following resident #2 to her room and left a trainee in the room with her while staff member I remained in the hallway. Staff member I stated resident #2 did not like her, and would become angry if she entered her room so she was staying back and allowing the trainee to stay with her. Staff member I stated she did not know what the care plan stated for the resident's behaviors or interventions. Staff member I stated the only trigger she knows of is resident #2 did not like her. Staff member I stated she completed the 15-minute checks form, and returned them to the nurse on duty. Staff member C stated she had not been trained on how to handle behaviors. During an interview on 7/30/24 at 8:18 a.m., staff member E stated she did not know where the 15-minute check forms were going, and they were probably filed away somewhere. Staff member E stated she had not reviewed the 15-minute check forms in the three weeks she had been at the facility. During an interview on 7/30/24 at 9:06 a.m., staff member J stated, The behaviors have been a learning process. We took [resident #2] back from [hospital name] because they said her behaviors were better. [Resident #2's] behaviors came right back when she returned, and we are not equipped to handle it (behaviors). Staff member J stated, We should review the 15-minute checks, but we haven't so I don't think anyone really looks at them. Staff member J stated none of the CNAs like being the sitter for the residents with behaviors, and she had to have a meeting to tell all CNAs they were to take turns, and all share the sitter time. During an interview on 7/30/24 at 10:26 a.m., staff member E stated there were seven residents with aggressive behaviors on the unit that she was aware of. Staff member E reported the residents on the unit exhibited behaviors which included: hitting, kicking, pinching, yelling, throwing things, and cussing. Staff member E stated, They (CNAs) really don't have the skills to care for these behaviors. I don't even know how I would handle some of them in the moment. During an interview on 7/30/24 at 10:44 a.m., staff member N stated resident #3 hits, kicks, cusses, and yells when staff try to change his brief. Staff member N stated, We just hope for the best, and get it done. It's hard and all they (management) say is we have to do it (check and change). During an interview on 7/30/24 at 11:37 a.m., staff member K stated, I feel burned out with all this aggressiveness. I don't even want to come in. I try to get someone to cover. During an interview on 7/30/24 at 11:38 a.m., staff member L stated she felt overwhelmed at times by the behaviors. Staff member L stated most days the staff dealt with more behaviors than ADL cares. Staff member L stated she had not received training on managing aggressive behaviors. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #2's Care Plan, updated 7/1/24, reflected: -I have the potential to be a safety risk to self and others due to my paranoid like schizophrenia and aggressive history of unprovoked behaviors towards others. - I would benefit from clinical medical management in a geriatric psych setting. Review of resident #2's CNA Kardex, dated 4/15/24, reflected: -Provide 1:1 staff to resident monitoring when resident is up out of bed and in common areas by keeping resident in line of sight. -Redirect to her room if resident appears agitated or aggressive or vocalizes threatening statements. -Attempt non-pharmacologic interventions when resident exhibits behaviors such as agitation, pacing, wandering, disorganized thoughts. Encourage walking, offer emotional support, allow her to watch a movie, provide a snack and/or fluids, sit with her, provide a calm, quiet environment with decreased stimuli. There was no documented indications of triggers. Review of resident #2's Nursing Progress notes, dated 6/29/24 - 7/30/24, showed the resident had a pattern of agitation, cursing, and kicking at other residents and staff. There was no identification of triggers or attempts to determine the root cause the behaviors. Review of resident #3's Care Plan, revision date of 12/31/24, reflected: -New Behavior Potentially Causing Harm to self of others (Episodic). Resident was in physical altercation with another resident causing harm to other resident on 11/30/23. -If Resident poses a potential threat to injure self or others notify provider - If safe, allow Resident personal space - If wandering or pacing, initiate visual supervision during acute episode - Minimize environmental stimuli - Monitor Resident for signs / symptoms of agitation - Provide verbal feedback to Resident regarding behavior - Utilize diversion techniques as needed Review of resident #3's Progress Notes, dated 7/16/24, reflected: (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Social services were asked to assist with the resident having aggressive behaviors when nursing staff is trying to change his pants and underwear, which the resident soiled. The resident began to be combative and swinging at CNAs and DON. The resident was transferred from the commons couch to wheelchair while still combative. Staff was able to get the resident to his room, where he tried to hit and bite staff. Staff eventually changed the resident and the resident calmed down.