Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	12/04/2024

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 48262 Based on interview and record review, a resident was acting out aggressively, and the staff restrained the resident for a Period of Imminent Danger to the Safety and Well being of others, and failed to ensure the required steps were taken to address the emergency restraint immediately after it occurred, or for future events in which a restraint may have been needed for this resident, for 1 (#2) of 1 sampled resident. Findings include: A review of a facility-reported incident, dated 11/11/24, revealed the following: On 11/13/24, at approximately 4:30 p.m., a personal care attendant (PCA) reported to the administrator-in-training that she had sustained an injury on 11/11/24, while assisting the charge nurse and other staff in physically restraining resident #2. During the investigation staff reported on 11/11/24, around 10:00 a.m., the charge nurse directed staff to physically restrain resident #2, due to the resident exhibiting physical aggression toward staff, and other residents. This restraint was implemented to allow the charge nurse to administer an intramuscular injection of an antipsychotic medication. The charge nurse instructed staff to continue restraining the resident for an additional fifteen minutes after the injection to allow the medication to take effect. After fifteen minutes, the charge nurse directed three staff members who were physically restraining resident #2 to resume their other assigned duties, leaving the PCA and security staff member to continue restraining resident #2 for a total of one hour until the resident fell asleep. Steps were not taken to ensure future restraint use was addressed for the resident and his behaviors. During an interview on 12/3/24 at 12:03 p.m., staff member E stated, on 11/11/24, resident #2 had attempted to hit, kick, and spit at staff and other residents in the facility. Staff member E stated the charge nurse requested staff member E to physically restrain resident #2, by holding her hand under the resident's left ankle while the nurse administered an intramuscular injection in the residents left arm. Staff member E stated the charge nurse requested resident #2 be physically restrained by staff for an additional fifteen minutes for the medication to take effect. Staff member E stated she did not hold the residents left leg down continuously but did restrain the resident at times by holding his left ankle when resident #2 attempted to kick at staff. The staff failed to ensure the least restrictive restraint was used, and verify with the nurse it was safe to continue restraining the resident throughout the hour period. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 2:20 p.m., staff member G stated on 11/11/24 she was summoned by the charge nurse to assist in physically restraining resident #2's right lower leg, while the charge nurse administered an intramuscular medication to the resident. Staff member G stated resident #2 had been physically aggressive to staff and residents on the morning of 11/11/24, by attempting to hit, kick, and spit. Staff member G stated after the charge nurse administered the medication, she left the resident's room and continued her other assigned duties. The nurse did not verify with the staff the least restrictive method of restraint was to be used. During an interview on 12/4/24 at 2:51 p.m., staff member J stated, on 11/11/24, resident #2 was destructive and swung at and punched staff. Staff member J stated the charge nurse asked him and another staff member to hold resident #2 down, while she administered an intramuscular medication. Staff member J stated he held resident #2's wrist, off and on, when the resident was trying to hit staff. Staff member J stated when resident #2 would calm down he would let go of the resident's wrist and try to talk to the resident. Staff member J stated resident #2 attempted to get out of bed, and the charge nurse instructed him not to allow the resident to get out of bed because he was a fall risk. Staff member J stated, I was just kind of confining him to an area but not being forceful. The Appendix PP, of the State Operations Manual, addressing restraints, shows: . the order from the practitioner and supporting documentation for the use of a restraint must be obtained either during the application of the restraint, or immediately after the restraint has been applied. The failure to immediately obtain an order is viewed as the application of restraint without an order and supporting documentation . If application of a restraint occurs, the facility must: - Determine that a physical restraint is a measure of last resort to protect the safety of the resident or others; - Provide ongoing direct monitoring and assessment of the resident's condition during use of the restraint; - Provide assessment by the staff and practitioner to address other interventions that may address the symptoms or cause of the situation (e.g., identification of an infection process or delirium, presence of pain); - Ensure that the resident and other residents are protected until the resident's behavioral symptoms have subsided, or until the resident is transferred to another setting; - Discontinue the use of the restraint as soon as the imminent danger ends; and - Immediately notify the resident representative of the symptoms and temporary intervention implemented. Documentation must reflect what the resident was doing and what happened that presented the imminent danger, interventions that were attempted, response to those interventions, whether the resident was transferred to another setting for evaluation, whether the use of a physical restraint was ordered by the practitioner, and the medical symptom(s) and cause(s) that were identified. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The steps identified as required in the Appendix PP, under F604 - Restraints, were not followed by the facility for the emergent restraint use for resident #2, or to address future potential episodes of imminent danger.

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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. 48262 Based on observation, interview, and record review, the facility failed to update a resident's individualized care plan for personal preferences related to communication and the provision of ADL care from male staff who had the ability to speak the resident's native language. When male staff assisted the resident, and used the resident's native language when communicating, the resident would exhibit less agitation and aggression, for 1 (#2) of 7 sampled residents. Findings include: During an observation and interview on 12/3/24 at 2:45 p.m. resident #2 was observed sitting in his wheelchair speaking his native language with staff member H. Resident #2 appeared happy, smiling at times, and responsive during the interaction. Resident #2 stated he preferred male staff who spoke his Crow language to care for him stating, white people are okay. During an interview on 12/3/24 at 2:55 p.m., staff member H stated resident #2 preferred male staff to care for him who speak his native Crow language. Staff member H stated resident #2 was less aggressive and more compliant with daily care with male Crow-speaking staff. Staff member H stated resident #2's preferences should be reflected on his current care plan and was not sure why it was not listed under the care plan's interventions. During an interview on 12/4/24 at 12:08 p.m., staff member B stated resident behaviors were discussed each morning at stand up (the facility's daily meeting) and if updates were needed to a resident care plan, it would be assigned to herself or staff member D. Staff member B stated the morning meeting is how they determined resident #2 responded better with a male staff who spoke his native language. Staff member B stated the missing interventions on resident #2's care plan was an oversight, and they (the facility staff) were getting better at developing individualized resident care plans. Review of resident #2's care plan, with a revision date of 11/18/24, failed to show the resident preferred male staff who spoke his native language, during the provision of ADL, as it would decrease the resident's agitation and aggressive behavior towards others.

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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. 48262 Based on interview and record review, facility failed to ensure all nursing staff working with a resident who exhibited aggressive behaviors towards others, was educated to the extent necessary and competent to provide services for the resident's needs to be met for behaviors and use of restraints; and to ensure restraint use was utilized properly for resident safety, in the event of an emergency situation; and failed to ensure all staff working with the resident when a restraint was applied had necessary training for physicial restraint use, for 1 (#2) of 7 sampled residents. The deficient practice resulted in a resident being physically restrained for up to one hour without nursing oversight. Findings include: A review of a facility-reported incident, dated 11/11/24, showed the following information: On 11/13/24, at approximately 4:30 p.m., a personal care attendant (PCA) reported to the administrator-in-training that she had sustained an injury on 11/11/24, while assisting the charge nurse and other staff in physically restraining resident #2. During the facility's investigation, staff reported on 11/11/24, around 10:00 a.m., the charge nurse directed staff to physically restrain resident #2, due to the resident exhibiting physical aggression toward staff and other residents. The restraint was implemented to allow the charge nurse to administer an intramuscular antipsychotic injection. The charge nurse instructed staff to continue restraining the resident for an additional 15 minutes after the injection to allow the medication to take effect. After 15 minutes, the charge nurse directed three staff members who were physically restraining resident #2, to resume their other assigned duties, leaving the PCA and a security staff member to continue restraining resident #2 for a total of one hour until the resident fell asleep. During an interview on 12/3/24 at 2:59 p.m., NF2 stated resident #2 had become aggressive with staff and residents at approximately 9:00 a.m. on 11/11/24. NF2 stated nursing staff had tried to redirect the resident, but interventions failed. NF2 stated she contacted the medical provider and received an order for the resident to have intramuscular antipsychotic injection to help with his aggressive behaviors. NF2 stated she gave resident #2 the injection at around 10:00 a.m., and requested staff physically restrain resident #2 for fifteen minutes until the medication would take effect. NF2 stated she returned to resident #2's room after fifteen minutes, and the resident was still aggressive and agitated. NF2 stated she had a male staff member stay with resident #2, and continue to physically restrain him for safety. NF2 stated she did not reassess or document the resident's condition every 15 minutes after her initial assessment. Review of resident #2's electronic medical record failed to show resident #2 was re-assessed at any time by nursing staff during the one hour period of physical restraint on 11/11/24. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/24 at 12:08 p.m., staff member B stated the nurse involved in the restraint incident was a brand-new graduate who had just passed her nursing boards. She stated after the incident management had reviewed the Haldol usage and interviewed other nurses about resident #2, and she believed it was the new nurse who was having the most difficulty. Staff member B stated there should be an assessment before resident #2 received the injection, a justification with exactly what he was doing, what interventions weren't working, and then the Haldol. Staff member B stated when giving the intramuscular shots the practice should be not holding him for any longer than it takes, just long enough to make sure he doesn't hit or kick, and then letting him go. During an interview on 12/4/24 at 2:51 p.m., staff member J stated on 11/11/24 resident #2 was destructive and swung at and punched staff. Staff member J stated the charge nurse asked him and another staff member to hold resident #2 down while she administered an intramuscular medication. Staff member J stated he held resident #2's wrist off and on when the resident was trying to hit staff. Staff member J stated when resident #2 would calm down he would let go of the resident's wrist and try to talk to the resident. Staff member J stated he did not receive any training from the facility on how to restrain a resident, and it was the first time he had any physical contact with a resident. Staff member J said prior to the incident on 11/11/24, he would call a CNA if a resident needed help. Staff member J stated he knew he was not to provide any hands-on care. Staff member J stated he was doing what he was told to do by the facility supervisor at the time. Review of staff member J's personnel file failed to show documentation of training or education regarding resident care or restraint use. During an interview on 12/4/24 at 3:00 p.m., Staff member C stated the aides would sometimes ask the nurse to get the resident a shot for behaviors, but it was up to the nurse to evaluate if it was appropriate not to just give it.