STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275156	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwest Montana Veterans Home	65 Veterans Circle Butte, MT 59701

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245 Based on interview, observation, and record review, the facility failed to allow the POA and decision-maker of the resident to make food preference requests that followed the physician orders, dietary preferences, and swallowing precautions for 1 (#15) of 17 residents. Findings include: During an interview on 6/4/24 at 9:50 a.m., NF1 stated she brought in extra food to provide more nutrition and prevent weight loss for her family member, resident #15. NF1 stated the food brought in was pureed and followed the diet prescribed by the physician. NF1 stated, It seemed that he really liked them because he would eat them quickly. NF1 stated the food was sometimes located in squeeze packets, and some of the staff members considered it to be a dignity issue. Due to the concern for dignity, staff would refuse to let NF1 give the squeeze packets to resident #15. NF1 stated staff had expressed concern that the packets may have looked childlike or very colorful, like they were for children. NF1 stated, I even purposely bought the squeeze packets that said for adults on the back of the package. With tears of frustration, NF1 stated, I know what he likes; and he eats it! So, what's the big deal? These are store bought items that anyone could eat. What's the difference? Review of resident #15's physician orders showed a diet: controlled carbohydrate, pureed texture, thin consistency. Review of resident #15's Care Plan, initiated on 3/18/24, showed: Family aware not to provide [#15's name] with plastic pouches to eat food out of. During an interview on 6/5/24 at 11:25 a.m., staff member B stated resident #15 had delayed oral motor function and was on a pureed diet. Staff member B stated, Personally and professionally, I do not see it (squeeze packages) as an issue. Staff member B stated, there was no risk of choking with these packages as they were either liquid or pureed. Staff member B stated NF1 was the only one who gave resident #15 the food pouches, and often it was in his room where no one could see. Staff member B stated she would not be embarrassed drinking one of those packages in the main dining room, in front of the surveyor, or in front of other staff members. During an interview on 6/5/24 at 11:39 a.m., staff member D stated, the squeeze packages for resident #15 were not needed and were viewed as a supplement because he was given his main sources of nutrition from the facility kitchen. Staff member D stated drinking out of the food packages would not embarrass her if she were drinking it in a public area. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 12:36 p.m., staff member E stated, NF1 was dedicated to resident #15 and really wanted to help. Staff member E stated, In [NF1]'s eyes, nutrition equals health. And when you think of these residents, food is one of the 'last pleasures in life.' Staff member E stated, I don't see this as a dignity issue. The drinks add extra nutrition; he's progressed in his dementia where he really wants the sweet foods, so he really drinks these (squeeze package foods) up and does not really refuse these (squeeze package foods). We always try our food of course, but he may not always eat it. Staff member E stated, This even went as far as us (staff) asking the psychiatrist if it was a dignity issue, which he said it wasn't. He said dignity issues are subjective. When asked if staff member E would feel uncomfortable or embarrassed eating the squeeze package foods in front of someone, staff member E stated, No, I would not. Of course not. I have eaten them at lunch before. My daughter eats these too. During an observation on 6/5/24 at 1:12 p.m., resident #15 was observed to have numerous squeeze package foods in his room. One squeeze package food labeled Organic Beef Medley contained the following macronutritents: 2.5g of total fat, 9g of carbohydrates, 4g of protein. The following ingredients were in this package: water, organic carrots, organic potatoes, organic ground beef, organic parsnip puree, organic diced tomaoes, organic rutabaga puree, organic onions, organic [NAME]. The outside of the packaging was adult focused. It had a white background with pictures of realistic vegetables and cubes of beef on the front cover. No childlike colors were located on this specific packaging.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 46400 Based on interview and record review, the facility failed to ensure a mental health diagnosis was included in a resident's admission PASARR assessment for 1 (#21) of 17 sampled residents. Findings include: During an interview on 6/5/24 at 9:46 a.m., staff member C stated resident #21's diagnosis of bipolar disorder did appear to be dated back to his admission in 2021, but it was not listed as a diagnosis on the H&P that was submitted for his admission PASARR. Staff member C stated it depended on the situation, but typically if a resident was later diagnosed with a mental health diagnosis by their telepsych provider they would submit for a new PASARR evaluation. Review of resident #21's PASARR, dated 10/26/21, listed chronic obstructive pulmonary disease, post-traumatic stress disorder, and dependence on supplemental oxygen, as the resident diagnoses for the level 1 evaluation. There was no mention of bipolar disorder. Review of resident #21's Quarterly MDS, with and ARD of 1/13/24, Section I Active Diagnosis, showed the resident was identified as having a psychiatric illness: bipolar. Review of resident #21's [Psychiatric Provider Name] Initial Evaluation, dated 2/8/23, showed he had a background of Bipolar Unspecified. Review of resident #21's care plan, initiation date 4/4/24, showed: [Resident name] is at risk for alterations in mood and behavior r/t Bipolar . He is prescribed antipsychotic medication.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50245 Based on interview, observation, and record review, the facility failed to have a consistent process, evaluation, and management of the check-out process for allowing residents to leave the facility doors based on cognitive level, physical level, elopement risk, and wandering behavior, for 1 (#194) of 17 sampled residents, and this could increase risk of accidents or harm for any other residents exiting the facility, unattended, without signing out. Findings include: Review of a facility reported event, dated 9/30/23 at 1:00 p.m., showed resident #194 exited the facility on his scooter and went to an [outside facility store] which was located 0.3 miles away without notifying staff. Resident #194 returned to the facility without incident, and the facility reminded the resident and POA of the facility policy for leaving the facility, which was to sign out and notify staff. Review of resident #194's Elopement Assessment, dated 10/2/23, completed after the incident on 9/30/23, showed resident #194 to have wandering behaviors, to have wandered/eloped from their home without supervision prior to admission, to be cognitively impaired with poor decision-making skills, to have a history of leaving the facility without notifying staff, and was a risk for elopement. Review of the Resident Sign-Out Log showed: resident #194 signed himself out to go to an [outside facility store] that was located 0.3 miles away on 10/21/23. During an interview on 6/4/24 at 8:57 a.m., staff member F stated, They (residents) should tell us if they are leaving, and most do, but not always. During an interview on 6/4/24, staff member F stated the doors on Cottages 1, 2, and 3 were not locked for residents exiting the building. This could allow any of the residents who were elopement and at risk for wandering to freely exit the facility if not watched by staff. During an observation on 06/4/24 at 9:00 a.m., Cottage 1 was unlocked to go outside. During an interview on 6/4/24 at 3:53 p.m., staff member G stated each resident must tell the nurse if they are leaving the building, even to sit outside for a few minutes. Staff member G stated the residents always tell her and will never go outside without her permission. During an observation on 6/4/24 at 4:05 p.m., Cottage 2 was unlocked to go outside. During an interview on 6/4/24 at 4:08 p.m., staff member F stated resident #194, Had been on all kinds of narcotics (at the time of the facility reported incident). Review of resident #194's EHR showed the following medications were administered prior to resident #194 exiting the building on 9/30/23: - Fentanyl patch 72 hour 12 mcg/hr had currently been on as it was placed on 9/29/23 at 2:36 p.m. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lorazepam Oral Concentrate 2 mg/ml (0.25 mL) given at 9/30/23 at 7:00 a.m. - Pregabalin 150 mg given on 9/30/23 at 8:00 a.m. - Morphine 0.5 ml given on 9/30/23 at 9:05 a.m. and 12:01 p.m. - Morphine Oral Tab 15 mg on 9/30/23 at 9:24 a.m. During an interview on 6/5/24 at 12:36 p.m., staff member E stated, she had worked in all the cottages. Staff member E stated even if they were in Cottage 1, the residents still should be treated like they were in Cottage 4 (as far as safety), as each resident had a spectrum of abilities. Staff member E stated, sometimes these residents forget where they are or may forget their capabilities and weaknesses. Staff member E stated there have been multiple times where she, and the only other staff member on the floor, could get stuck in a room for several minutes due to a Hoyer lift. This could leave an opportunity for a resident to go out of the door who may not be safe outside, unattended. Staff member E stated there were many reasons why a resident would be unsafe outside alone. Staff member E stated a resident may fall, may have dementia, may have hypoglycemia, a medication effect, dizziness, or a new prosthesis that could affect a resident's safety outside alone. Staff member E stated there is a balance between allowing independence and safety, but she stated she feels there may be another option that would make her feel more comfortable regarding resident safety when she is unable to watch the doors all the time. A request was made on 6/5/24 at 3:21 p.m., for a list of residents that were allowed to self-check-out of the facility. Staff member A stated the facility did not have a list of approved residents allowed to self-check-out at this time.