| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 27A052 | A. Building<br>B. Wing | 07/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Montana Mental Health Nursing Home | 800 Casino Creek Dr<br>Lewistown, MT 59457 |

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 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>(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 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on interview and record review, staff assigned to deliver mail to residents failed to do so for an extended period, and the mail was found piled in an employee's office, undelivered; and some mail was time-sensitive or confidential. This failure involved 9 (#s 6, 7, 8, 9, 10, 11, 12, 13, and 14) residents out of 14 sampled residents. It was also identified that staff did not assist residents with cognitive impairments with opening or understanding the mail. Findings Include:Review of the facility investigation notes for a Facility Reported Event, dated 1/10/25, which was related to undelivered mail, showed:-Residents 6, 7, 8, 9, 10, 11, 12, 13, and 14 had either personal mail, legal mail, or holiday packages sent to the faculty, which were undelivered between October 2024 and the beginning of January 2025. -Resident #6 was interviewed on 2/6/25 but unable to answer. Review of facility staff email communication, dated 7/7/25, showed resident #6's guardian was contacted on 1/9/25 regarding the late mail delivery, and was not concerned. Review of the mail inventory, which was delivered late and found in NF2's office, showed resident #6 had a personal letter with a postal stamp date of October 25, 2024.-Resident #7 was interviewed on 2/6/25 but unable to answer. Review of facility staff email communication, dated 7/7/25, showed resident #7's guardian was contacted on 1/9/25 regarding the late mail delivery, and was not concerned.-Resident #8 was interviewed on 2/5/25 and stated, I'm not getting it. I want to get it (mail) faster.-Resident #s 9, 10, and 11 were interviewed on 2/6/25 and had no ongoing concerns related to the mail delivery.-Resident #12 was interviewed on 2/5/25 and had no concerns. Review of the late delivered mail inventory, found in NF2's office, showed resident #12 had a Social Security Administration letter with a postal stamp date of December 10, 2024. -Resident #13 was interviewed on 2/5/25 and had no concerns. Review of the late delivered mail inventory, found in NF2's office, showed resident #13 had a personal letter with a postal stamp date of November 4, 2024.-Resident #14 was interviewed on 2/5/25 and stated, I am not getting any mail. When they deliver the mail, make sure the mail is mine. Review of the late delivered mail inventory, found in NF2's office, showed resident #14 had a personal letter with a postal stamp date of August 17, 2024, and a Social Security Administration letter with a postal stamp date of December 10, 2024.-NF3 did not report the issue or deliver the mail and packages as directed. NF3 was put on administrative leave and ended employment on 2/28/25. -NF2 was on medical leave when notified of administrative leave, and then the employee resigned on 1/13/25, during the investigation. All residents' mail and packages were delivered, and the responsible parties were notified. No lasting effects of the late mail were found.During an interview on 7/29/25 at 1:32 p. m., NF1 stated there had been no issues with legal mail delayed to residents. There had been some late packages, but nothing that had caused a negative impact to a resident. NF1 stated there had been no further resident concerns related to resident mail delivery. NF1 spoke with all of the resident family members involved in the incident.During an interview on 7/29/25 at 4:11 p.m., staff member C stated another staff member had noticed packages piled in NF2's office and brought it to her supervisor, NF3. NF3 was told to deliver the packages, and when it was noted she did not complete the directive, she was placed on administrative leave. An investigation was completed, and the entire office was checked for any outstanding mail and packages. The packages were delivered by a case manager. The facility had notified all the responsible parties of those residents involved, to inform them of the investigation, with only two being upset. Staff member C stated all other residents were interviewed, who were assigned to NF2, and there were a few issues with her timeliness for the mail delivery. One resident was found to have given her two gifts, one was edible and was eaten, and in the trash at the time of her leave, but it was noted that she told the resident she could not accept gifts. The unused gift was returned to the resident. Staff member C stated that the process was that all mail was stamped with the date of delivery to the facility, packages were logged when delivered, and given to residents.During an interview on 7/30/25 at 11:17 a.m., staff member A stated the failure to deliver a resident's mail was more of a personal failure than a process one. Staff member A stated that the people involved no longer worked at the facility. Staff member A started daily spot checks on the mail sign-out and hired a new case manager, who was trained on the correct process. Staff member A stated the facility had followed up with Social Security on behalf of residents who received late letters to ensure there were no repercussions. Staff member A stated they had met with their QAPI team to investigate the occurrence, interviewed residents, and interviewed resident representatives who had been impacted by the late delivery. All staff completed abuse training by April 2025.QAPI met to review the event on 1/22/25.All staff training occurred on 3/19/25 and 3/20/25. The facility identified the concern with the mail delivery |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on interview and record review, the facility failed to notify the resident's physician, dietician, and representative in a timely manner of the resident's severe weight loss, for 1 (#1) of 14 sampled residents. Findings include:Review of resident #1's electronic health record reflected the resident lost 27 pounds in a three-month time period. This weight loss represented an 11.86% severe weight loss. The weight 229 lbs. was recorded on 6/2/25, and the weight of 209 lbs. was recorded on 7/22/25, which showed a 20# loss occurred in under 2 months. The documentation showed the resident had a severe weight loss. The medical record did not show that the physician, dietitian, or representative was immediately notified of the severe loss. Review of resident #1's nursing progress notes, dated July 2025, showed the following physician notifications:-The psych provider was updated on 7/23/25 of the resident's change in status and behaviors. -The medical physician was notified of the weight loss on 7/25/25 while rounding for the 90-day visit. A UA was ordered to investigate the resident's fatigue. A request was made on 7/29/25 for resident #1's nutrition notes.Review of resident #1's nutrition note, dated 7/29/25, showed the resident had lost 27 lbs. since admission. New orders of double portions at breakfast, weekly weights, and nutritional supplements for weight loss were initiated. Review of resident #1's nursing progress note, dated 7/30/25, showed, Late entry from 7/28/25. Called rsdt [resident] guardian at 1000 [10:00 a.m.] and informed her of (#1's) weight loss .A phone interview with resident #1's family was attempted on 7/29/25 at 2:15 p.m., with no return call received. During an interview on 7/30/25 at 1:54 p.m., staff member M relayed details of being notified of resident #1's weight loss in the last few days, and staff member M went over to see the resident yesterday (7/29/25). Staff member M had requested a weight reweigh, noting that anytime there was a five-pound difference in weight, that should occur. Staff member M stated that without a weight, it was difficult to function in the role for resident care [referring to the refusal in early July]. |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Based on observation, interview, and record review, the facility failed to identify two areas of concern, which were contributing factors for a resident's severe weight loss of 11.86% over 3 months, which included the resident's increased sedation [sleeping through meals], and the resident had an ADL decline. The facility did not address the two contributing factors timely manner, in an attempt to intervene and prevent the severe loss, for 1 (#1) of 14 sampled residents. Findings include:During an interview on 7/29/25 at 2:35 p.m., staff member O stated that when resident #1 was first admitted , he was very agitated. Now the resident had stabilized on his medications and was more mellow, and maybe he had a little bit of a decline. Staff member O stated the resident had gotten a lot easier to redirect and was he was not having behavioral issues.Review of resident #1's MDS admission assessment, with an ARD of 4/30/25, showed the resident was coded as needing set up and clean up only for eating. The resident was independent for toileting and ambulation. Review of resident #1's nursing progress notes, dated 7/2/25 - current, showed the following:-7/2/25 . Seems more 'out of it' than what this RN previously knew .-7/16/25 . 1:1 who had to encourage every bite of dinner. Res appeared sedated . [sic]-7/17/25 Resident slept all day this far. Was able to wake him up to take am and noon meds. He have very few bites of lunch . [sic]-7/17/25 . he was laid back down and immediately asleep. Res very sedated today. Very little intake. [sic]-7/19/25 [Resident #1] is sleepy this shift. Hard to rouse for check and changes .-7/21/25 [Resident #1] has been sleeping in recliner since before 1800 [6:00 p.m.]. He wouldn't wake to eat dinner or take meds. Is still in chair sleeping. Very somnolent and hard to rouse. [sic]-7/21/25 . did not wake up for lunch.-7/22/25 [Resident #1] is needing more assist with dressing, personal hygiene, toileting, and eating .-7/23/35 Res profoundly sedated this shift and is minimally responsive to staff. Res sits with eyes closed and is difficult to rouse . resident's sedation load is very high with the current medication profile of Seroquel, olanzapine, Haldol, Ativan, trazadone, Melatonin, and occasionally oxycodone. No behaviors noted this shift. [sic]-7/25/25 Res sedated but awake in dayroom after dinner. Minimal intake at dinner . [sic]-7/29/25 . Res requires almost 100% assistance from staff with ADLs. [sic]During an observation on 7/30/25 at 8:22 a.m., resident #1 was sitting in a wheelchair, and he was receiving full feeding assistance from staff with breakfast.Review of resident #1's documented weights showed:-4/24/25 236 lbs.-5/5/25 233 lbs.-6/4/25 229 lbs.-7/7/25 refused.-7/22/25 209 lbs. This represented an 11.86% severe weight loss over three months.A request was made on 7/29/25 for resident #1's nutrition notes to determine the implemented interventions for the severe weight loss. Review of resident #1's nutrition note, dated 7/29/25, showed the resident had lost 27 lbs. since admission. A reweigh was requested, and new orders for double portions at breakfast, weekly weights, and nutritional supplements were added for weight loss prevention. Review of resident #1's nursing progress note, dated 7/30/25, showed, Late entry from 7/28/25. Called rsdt [resident] guardian at 1000 [10:00 a.m.] and informed her of weight loss . The notification was not timely.During an interview on 7/30/25 at 10:38 a.m. staff member N stated resident #1 was on a medication called rivastigmine, a dementia medication, that had side effects of weight loss and loss of appetite. Staff member N stated resident #1 had some appetite loss, as he used to eat all his food, and loved sweets, like Reese's peanut butter cups. Staff member N stated the psych provider had been updated, and a medication taper had been initiated. Staff member N stated that the July weight for #1 was not done by the staff member who normally did the weights, and the facility was attempting to locate more information. Staff member N stated that any resident having more than a five-pound discrepancy would need to have a reweigh completed, and if a resident refused, they should be reapproached at another time.During an interview on 7/30/25 at 11:52 a.m., staff member J stated the pharmacy reviews were completed monthly, and the pharmacist looked at nursing notes, physician orders, labs, physician notes, and the medication administration report for the as-needed medication usage. Staff member J stated if there was a lot of documentation related to a resident being excessively sedated, the pharmacy would look at psychiatric medications and pain pills, and if the resident was getting a whole bunch of PRNs (as needed medications) they would look to see if a certain time of day was where the sedation was occurring to correlate to medication timing. Staff member J was unsure when resident #1's most recent pharmacy review occurred. During an observation on 7/30/25 at 12:26 p.m., resident #1 was getting full feeding assistance at lunch. His eyes were closed, and he was restless and fidgeting in the recliner.During an interview on 7/30/25 at 1:54 p.m., staff member M stated they were notified of resident #1's weight loss, . just in the last few days, and was over to see the resident yesterday (7/29/25). Staff member M requested a |