STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27A052	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montana Mental Health Nursing Home	800 Casino Creek Dr 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 14005 Based on interview and record review, the facility failed to address the timely completion or implementation of treatment wishes, specifically related to the Provider Orders for Life-Sustaining Treatment (POLST) forms, for 2 (#s 43, and 60); and failed to ensure advanced directives were in place for 1 (#37) of 29 sampled residents. Findings include: 1. Resident #43 said she remembered being asked about her code status by the staff at the facility. A review of resident #43's admission records, showed the POLST was not completed for over thirty days after #43's admission, to address her treatment wishes. 2. Review of the admission form showed resident #60 was admitted on [DATE], and the POLST form for treatment wishes was not completed until 10/16/23. This was almost two months after the resident's admission, and the timeline did not correlate with the facility policy. During an interview on 10/24/24 at 9:11 a.m., staff member I stated in the absence of a POLST the staff would consider the resident a full code. Due to this, if a resident wished to be a DNR, but did not have treatment wishes determined and documented in the medical record on admission, the resident may receive treatment they did not wish to have. During an interview on 10/23/24 at 8:45 a.m., staff member A stated the physicians were the only staff allowed to complete the POLST forms at the facility. Staff member A said the POLST may not be completed until the physician or nurse practitioner makes their initial visit which may not be very often. Staff member A stated the facility had been completing audits of the POLST's as part of QAPI. During an interview on 10/24/24 at 9:11 a.m., staff member I stated the physicians were the only ones to complete the POLST forms at the facility. Staff member I said she would not trust other staff to be able to know how to complete the forms. It would be typical for the physician to not see the resident for two to three weeks after their admission to the facility, and per staff member I's interview, the resident would be considered a full-code, unless treatment wishes were already established. 49554 (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of resident #37's medical record showed there was no advanced directive filled out, and her progress notes failed to show a discussion was had regarding her wishes. Resident #37 was admitted to the facility on [DATE]. Review of resident #37's initial visit provider notes failed to show the resident's provider discussed the right to advanced directives and the resident's wishes. A request was submitted to the facility for information regarding an advanced directive or a refusal for resident #37. The facility did not provide this information prior to the end of the survey. During an interview on 10/24/24 at 9:50 a.m., staff member B stated the resident's provider will discuss advanced directives and assist the resident with filling out the POLST, upon the initial provider visit, which is within the first thirty days after admission. Staff member B stated, We conduct monthly audits of the resident charts to ensure the POLST is present and properly filled out for all residents. Review of a facility document titled Advanced Medical Directive (POLST) with a revision date of 2/6/23 showed: . Procedure: . B. If resident does not have a completed POLST at admit, their Provider will be notified to complete this for discussion with them and/or guardian at their first medical visit . 1. Resident and/or their guardians who do not wish to make any advance directives can note that on the Provider Orders for Life Sustaining Treatment . Review: 1. Advanced Medical Directive/POLST form will be reviewed annually by Social Services staff for proper completion and location within the chart. 2. Social Service staff will offer educational material to all interested families or guardians as requested . [sic]

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F 0580 Level of Harm - Minimal harm or potential for actual harm 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. 51133 Based on interview and record review, the facility failed to notify the guardian of a transfer to the emergency department, for 1 (#9) of 29 sampled residents. Findings include: Review of Emergency Department Reports from [Hospital] for resident #9, dated 10/20/24 at 11:34 p.m., showed the resident was admitted to the emergency department on 10/20/24 at 9:49 p.m. Review of resident #9's medical record lacked documentation that showed the resident's guardian was notified of the transfer to the emergency department on 10/20/24. During an interview on 10/23/24 at 1:47 p.m., NF1 stated she was not notified of the transfer to the emergency department on 10/20/24. During an interview on 10/23/24 at 3:40 p.m., staff member I stated the resident's guardian should have been notified when the resident was transferred to the emergency department. Staff member I stated the guardian for resident #9 was not notified of the 10/20/24 transfer to the emergency department. Review of the facility's policy, Scope of Social Services, revised 2/6/2023, showed, .Procedure: . D. Family Contact: . Contacts in coordination with nursing services will also be made with family and/or guardian when the resident's condition changes, or significant events occur.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49554 Based on interview and record review, facility staff failed to ensure an allegation of resident-to-resident abuse was reported to the State Survey Agency, within 24 hours after the allegation occurred, for 6 (#s 26, 37, 47, 53, 64, and 70) of 29 sampled residents. Findings include: 1. Review of a facility reported incident, dated 7/8/24 at 6:05 a.m., showed an allegation of resident-to-resident abuse for residents #64 and #47. This allegation occurred on 7/6/24, and was not reported to the State Survey Agency, until 7/8/24. 2. Review of a facility reported incident, dated 7/8/24 at 9:05 a.m., showed an allegation of resident-to-resident abuse for residents #64 and #47. This allegation occurred on 7/6/24, and was not reported to the State Survey Agency, until 7/8/24. 3. Review of a facility reported incident, dated 7/24/24, showed an allegation of resident-to-resident abuse for residents #70 and #26. This allegation occurred on 7/22/24, and was not reported to the State Survey Agency, until 7/24/24. 4. Review of a facility reported incident, dated 9/16/24, showed an allegation of resident-to-resident abuse for residents #37 and #53. This allegation occurred on 9/12/24, and was not reported to the State Survey Agency, until 9/16/24. During an interview on 10/23/24 at 8:10 a.m., staff member J stated, Floor staff report any incidents (of abuse/neglect) to the nurse working. They (nurses) are supposed to fill out a report on a behavior sheet. During an interview on 10/24/24 at 10:10 a.m., staff member A stated, We have an abuse team who oversees investigating facility incidents. The nurse on duty would send an alert via Tiger Text, a confidential texting application, to the team. The team would designate an individual to investigate the concern and submit it through BOUNDS (facility on-line reporting system). I review all allegations and ensure they are submitted timely . Review of a facility document titled, Abuse, Misappropriations, and/or Neglect of Residents with a revision date of 6/6/24, showed: . INVESTIGATION OF ABUSE, NEGLECT, OR MISAPPROPRIATION: The facility conducts an internal investigation. The process is as follows: 1. Administrator and Quality Coordinator initially inputs the alleged abuse report into the Bounds system within 24 hours .

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on record review and interview, the facility failed to implement an effective discharge planning process for 1 (#67) of 1 sampled resident, who left the facility Against Medical Advice. Findings include: A review of court documents, dated [DATE] showed resident #67 was required to stay at the facility due to a court commitment which showed he was to be there for a minimum of 90 days. A review of resident #67's medical record showed an admitted [DATE]. A review of nurse's notes, dated [DATE], showed resident #67 did not want to remain at the facility and was exit seeking. A review of nurse's notes, dated [DATE], showed resident #67 wanted to go home. A review of case management notes, dated [DATE], showed resident #67 wanted to return home. A review of the interdisciplinary team admission assessment, dated [DATE], showed the resident#67's primary mode of locomotion was a wheelchair. A review of a note written by the nurse summarizing the nurse practitioner's visit, dated [DATE], showed resident #67 voiced his desire to return home. A review of nurse's note written by a nurse summarizing the nurse practitioners visit dated [DATE], showed resident #67 was not happy and did not want to remain in the facility. The note showed resident #67 wanted to be somewhere he could smoke. A review of a nurse's note dated [DATE], showed resident #67 was discharged against medical advice. The note showed the resident was given three days' supply of his medications. The note showed the resident should make an appointment to see his physician. A review of an email, which was written on [DATE], showed a miscommunication was made, and the re-commitment had been missed. The failure to obtain a re-commitment allowed resident #67 to be in the facility on a voluntary basis. During an interview on [DATE] at 8:45 a.m., staff members A and E were both interviewed. Staff member A said resident #67's court commitment expired, and a re-commitment had not been filed in time. Staff member E said there was no discharge planning being done as resident #67 was happy being in the nursing home. Staff member A said the discharge planning also had not been started as there were some financial issues needing worked through, as resident #67 was co-owner of a house. Staff member E said no discharge planning was completed as the resident did not show he was unhappy and wanted to leave the facility. Staff member E said there were no post discharge accommodations being made for the resident to include a follow up appointment, ensuring resident #67 had a wheelchair for use and would have enough medication until he could get a prescription, as the staff assumed resident #67 would stay in the facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders for discharging against medical advice were not found in resident #67's chart. No orders for directing the staff to send a three-day supply of medications was found in the medical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 14005 Based on observation, interview, and record review, the facility failed to ensure 1 (#43) of 29 sampled residents was administered oxygen at the rate the physician had prescribed, and ensure respiratory equipment was maintained in a manner of acceptable parameters. Findings include: During an observation on 10/22/24 at 8:59 a.m., resident #43 was observed using oxygen per a nasal cannula connected to an oxygen concentrator. The oxygen cannula was lying on the floor, and the nose pieces were directly in contact with the floor. The oxygen concentrator was turned on at a rate of two and one-half liters per minute. The oxygen air inlet filter, on the right side of the machine, had a fine layer of gray particles present. The air inlet filter, on the left side of the machine, had a heavy layer of particles and hair-like substance present. Resident #43 said she did not know there was even a filter on the other side, and she had not cleaned it. Resident #43 took the filter and was observed to peel the layer of debris off the filter. Review of a physician's order written on 5/24/23, showed resident #43 was ordered to have oxygen up to 5 liters per minute. The order did not include parameters for how the oxygen would be delivered. During an observation on 10/23/24 at 2:15 p.m., the oxygen concentrator setting was observed to be at two and one-half liters of oxygen per minute. During an interview on 10/24/24 at 9:11 a.m., staff member I said the night shift cleans the oxygen concentrator filters once a month. The company the oxygen concentrators are rented from come quarterly and do preventative maintenance. Review of the certified nurse assistant documentation flow sheets, for October 2024, showed the oxygen filter for #43 was scheduled for cleaning on 10/18/24, but had not been signed as completed. Review of resident #43's current and active physician orders, dated 10/1/24 through 12/31/24, showed supplemental oxygen: up to 5 liters via nasal canula prn for hypoxia. Review of resident #43's monthly medication administration records and treatment records for two unlabeled months showed no oxygen monitoring results, or that the oxygen liter flow had been documented for the two months reviewed. A review of the facility's policy, titled Oxygen Therapy, dated 4/16/21, showed the following: .- Administer 2L (liters) of O2 via nasal cannula (n/c) with titration to maintain SpO2 level at 90% or greater . Assess SpO2 as needed after applying O2 to adequately titrate O2 further . Air inlet filter on the concentrator is washed and rinsed in warm soapy water at least monthly and as needed .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on observation, interviews, and record review, the facility failed to ensure expired immunizations which were stored in 1 of 2 medication refrigerators in the treatment room were properly disposed of. The facility failed to monitor the treatment room and unit medication refrigerator and freezer temperatures. This failure created the potential for residents to experience negative effects related to the administration of expired Shingrix immunizations and negative effects related to inadequately monitored medication and immunization refrigerator and freezer temperatures. Findings include: During a record review on [DATE] at 9:55 a.m., the treatment room immunization freezer temperature logs were not completed for the following dates: [DATE], 7, 15, 16, [DATE], and [DATE]. The treatment room immunization (Med-Lab Performance) refrigerator logs were not completed for the following dates: [DATE], 7, 15, 16, [DATE], and [DATE]. During an observation and interview on [DATE] at 9:58 a.m., in the treatment room refrigerator/freezer, a box of expired Shingrix vaccines labeled 'Zoster Vaccine Recombinant, Adjuvanted' with a lot number of FH79Y, manufacturer GlaxoSmithKline Biologicals, with an expiration date of [DATE], was on a shelf. Staff member L stated expired immunizations were brought to the pharmacy to be returned and replaced. Staff member L stated staff member K usually brings them to the pharmacy when they are expired, and Staff member K is in and out of here (the treatment room) a lot during the day, and I'm surprised this is in here. I check the temps too, but I am busy with the doctors during the day. During an interview on [DATE] at 10:04 a.m., staff member K stated she would check the treatment room fridge often, Daily, when I am here. The immune fridge temps are checked by the night shift nurses when [staff member L] or myself are not there to check, such as on weekends or holidays. Review of a facility document labeled, 'Glacier Med Fridge Nurses Station 2024' showed: Fridge Temp Range: Medications= 36 F - 45F . P.M. and Night nurses check refrigerators when doing narcotic counts. There was no documentation on the log for temperatures on [DATE], 6, 10, or 30th. The log showed no documentation for temperatures on [DATE]. Review of a facility document, '[Facility] Shift to Shift Charge Report', showed, Charge concerns . All refrigerador temps documented including vaccine fridge in treatment room? [sic] Review of a facility document of an unlabeled nurse task list showed, On the weekends it is the charge duty to check all fridge temps. Use the temp book provided by the infection control nurse. Review of a facility policy, 'Temperature log' with an original date of [DATE], showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. Department: Infection Prevention and Control. [Facility Name] will maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This protocol also addresses refrigerated storage . Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. a. Temperatures will be checked and logged at least daily by designated personnel .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51111 Based on observation, interviews, and record review, the facility failed to ensure the consistent practice of properly dating and labeling open foods, storing food, and monitoring food temperatures in unit refrigerators and freezers. This failure had the potential to lead to food borne illnesses and improper infection control practices for residents consuming food from the refrigerators and freezers on the Glacier and Firefly units. Findings include: During an observation on 10/21/24 at 3:05 p.m., the Firefly unit kitchen refrigerator and freezer had a log with no documentation of temperature recordings on 19 of 24 opportunities, and there was no documentation on October 5, 8, 12, 14, and 19, 2024. During an observation on 10/21/24 at 3:07 p.m., the Firefly unit kitchen freezer had a Styrofoam bowl with food that had a white topping, unlabeled with no name or date, covered with a paper towel, with a plastic spoon sticking out of the paper towel covering. During an observation on 10/22/24 at 8:56 a.m., the Firefly unit kitchen refrigerator and freezer had a log with no documentation of temperature recording for 19 of the 24 days to complete the temperature recordings. Documentation was missing for October 5, 8, 12, 14, and 19. During an interview on 10/23/24 at 4:52 p.m., staff member Q, who was working on the Glacier wing, stated it was the night shift nurses responsibility for following the nursing task list which included the completion of refrigerator and freezer documentation on all units. During an interview on 10/24/24 at 9:52 a.m., staff member I stated the night shift charge nurses were responsible for checking refrigerator and freezer temperatures on all units and logging the temperatures. Review of a facility provided log, labeled, 'Firefly 2024 Food Fridge @ Nurses Station,' showed: Fridge Temp Range: Food = 36 F - 40 F . P.M. and Night nurses check refrigerators when doing narcotic counts. There was no documentation on the log for temperatures on July 9, 25, 26, 30 of 2024. The log showed no documentation for temperatures on August 14 of 2024. The log showed no documentation for temperatures on September 3, 9, 10, 24 of 2024. The log showed no documentation for temperatures on October 4, 5, 6 of 2024. Review of a facility provided log labeled, 'Glacier 2024 Food Fridge Nurses Station', showed: Fridge Temp Range: Food = 36 F - 40 F . Freezer: 0 Fahrenheit or below . P.M. and Night nurses check refrigerators when doing narcotic counts. There was no documentation on the log for temperatures during the month of July crossed out and written in as January for 8, 13, 28, 29. The log showed no documentation for temperatures on October 17. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility document, '[Facility Name] Shift to Shift Charge Report,' showed, Charge concerns . All refrigerador temps documented including vaccine fridge in treatment room? [sic] Review of a facility document of an unlabeled nurse task list showed, On the weekends it is the charge duty to check all fridge temps. Use the temp book provided by the infection control nurse. Review of a facility policy 'Temperature log' with an original date of 8/29/24, showed: . Department: Infection Prevention and Control. [Facility Name] will maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This protocol also addresses refrigerated storage . Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. a. Temperatures will be checked and logged at least daily by designated personnel . 3. All refrigerated storage must be maintained at or below 41 degrees Fahrenheit, unless otherwise specified. 4. All frozen storage must be maintained at or below 0 degrees Fahrenheit, unless otherwise specified . 7. Refrigerated food shall be labeled, dated, and monitored so that it is used by the use by date, frozen, or discarded, whichever is applicable.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 14005 Based on interview and record review, the facility failed to ensure resident medical record documentation was dated appropriately, labeled with the resident's information, and completed in entirety, for 4 (#s 11, 43, 60, and 66) of 29 sampled residents. Findings include: Incomplete Medical Record Documenation: 1. Review of resident #11's hard-copy POLST form, showed: - In the section for the person preparing the form and date section, the form was incomplete for the person preparing the form and the form was not dated when signed by the resident's legal decision maker. - The section for the provider phone number was incomplete. 2. Review of resident #43's hard-copy POLST form, showed: - In the mandatory section, where the signature was for the person completing the form, was blank. - The phone numbers for the person completing the form, and the physicians phone number, were incomplete. Resident #43 said she remembered being asked about code status by the staff at the facility. 3. Review of resident #60's hard-copy POLST form, showed: - In the mandatory phone number section, the form did not have the telephone number of the medical provider. During an interview on 10/23/24 at 8:45 a.m., staff member A stated the physicians were the only staff allowed to complete the POLST's at the facility. Staff member A said the POLST may not be completed until the physician or nurse practitioner makes their initial visit, which may not be very often. Staff member A stated the facility had been completing audits of the POLST's as part of QAPI. During an interview on 10/24/24 at 9:11 a.m., staff member I stated the physicians were the only ones to complete the POLST's at the facility. Staff member I said she would not trust other staff to be able to know how to complete the forms. 4. Review of resident #66's note with page titled, interdisciplinary progress note, showed no identifying information listed in the boxes marked resident last, and first name, physician, medical record number and room/bed. The nursing notes on this page were dated 9/30/24 and 10/2/24. A reader would not know which resident the form was for, due to the lack of information. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of resident #43's monthly medication administration record showed two sets of medication administration records were provided. Both sets were numbered one through three at the bottom of the page. The pages were not labeled as to month or year. The only dates on the monthly medication administration records were residents #43's date of birth and the date of her admission. It was unclear what the dates were for the MARs. During an interview on 10/24/24 at 10:36 a.m., staff member B was unable to identify the month resident #43's medication administration records were labeled.