STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275030	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE & REHAB - PARK PLACE	1500 32ND ST S GREAT FALLS, MT 59405

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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 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** Based on observation, record review, and interview, the facility failed to maintain a wheelchair and seating system in a sanitary manner for 1 (#19); failed to ensure a clean environment in a resident's room for 1 (#7) of 26 sampled and supplemental residents. The facility also failed to ensure resident rooms and bathrooms were maintained in a sanitary condition for 11 of 17 bathrooms on the 500 hall; for 3 resident rooms and bathrooms (104, 105, and 106) of 21 rooms on the hall; and for 8 resident rooms and bathrooms (106, 107, 108, 300, 301, 306, 307, 308) of 12 bathrooms on the 100/300 halls. Findings include: 1. Cleanliness concerns on the 100/300 units - WHEELCHAIR During an observation on 4/17/17 at 3:40 p.m., resident #19 was seated, in his wheelchair, near the 100 hall nurse's station. Attached to the wheelchair was a black 4-point seating system that buckled low across the waist. Dried white, tan, yellow, and brown substances were noted on the seating system which appeared to be dried food or fluid spills. Dust and loose debris that appeared to be dried food were on the frame of the wheelchair, and all four wheels had white spots and streaks, that appeared to be a spilled white liquid. There was also dirt on the wheel spokes; especially the left front wheel. During an observation on 4/18/17 at 8:00 a.m., resident #19 was seated, in his wheelchair, near the nurse's station. The seating system and wheelchair were unchanged from the previous day, and remained soiled. During an observation on 4/19/17 at 8:10 a.m., resident #19 was seated, in his wheelchair, near the nurse's station while a staff member worked on the wheelchair. The seating system remained soiled. During an interview with resident #19 on 4/19/17 at 8:10 a.m., the resident looked towards the surveyor, but made no response showing he understood. He was unable to make himself understood. Review of resident #19's MDS, with an ARD of 3/21/17, showed the resident was coded as rarely/never understood for his BIMS assessment. During an interview on 4/18/17 at 7:30 a.m., staff member H stated the night shift CNAs were responsible for cleaning wheelchairs. A review of a facility document titled, Night shift wheel chair wash list, showed that resident #19's wheelchair was scheduled to be washed every Friday. - ODOR During an observation on 4/17/17 at 9:30 a.m., during the initial tour, there was a urine odor in resident room 106, and the bathroom. The odor was stronger in the bathroom, which had a urinal dated 3/14/17. The urinal was hanging from the towel bar. The urinal lid was open and there were drops of a straw colored liquid in the bottom of the container which emanated a strong odor characteristic of urine. The bathroom floor had a dried yellow/brown substance to the left of the toilet, and in front of the toilet. This was on the baseboard to the right, and in front of the toilet. There was a used glove on the floor. In the resident room, the floor had a dried yellow/brown substance on the right side of the bed. During an observation on 4/18/17 at 7:15 a.m., an unpleasant odor, characteristic of urine, was noted on entrance to the 100 hallway. The odor increased towards the end of the hall where room 106 was located. During an observation on 4/18/17 at 8:45 a.m., there was a strong odor, characteristic of urine, in the bathroom of room 106. There was a urinal dated 3/14/17 hanging from the towel bar with the lid closed. The discolored areas on the floor and baseboard were unchanged from 4/17/17 at 9:30 a.m. During an observation on 4/19/17 at 7:30 a.m., an odor, characteristic of urine, was noted in room 106. The odor was stronger in the bathroom. A urinal dated 4/19/17 was sitting on the back of the toilet. During an interview, which was completed in room 106, on 4/19/17 at 7:33 a.m., staff member K was asked about an odor in the room and responded that the odor was not overwhelming. Upon entering the bathroom, staff member K stated the odor was stronger than in the bedroom. Upon returning to the bedroom, staff member K stated that there was a hint of a urine odor, but it's not overwhelming. During an interview on 4/18/17 at 4:30 p.m., questions were provided in writing for the resident due to his hearing deficit. The questions were about his room and how often he received a new urinal. Resident #22 showed verbally and non-verbally, through his expressions, that he could not understand. During an observation on 4/19/17 at 8:10 a.m., the window, in room 106, was observed to be open and there was an odor, characteristic of air freshener, in addition to the urine odor noted on 4/19/17 at 7:30 and 7:33 a.m. During an observation on 4/19/17 at 4:30 p.m., housekeeping staff were scrubbing the floor in room 106 with a floor cleaning machine. During an interview on 4/20/17 at 8:30 a.m., staff member H stated that urinals were changed out every day by the night shift. Staff member H withdrew the statement and said she was uncertain and would verify the information. Staff member H did not provide a clarification for when the urinals were changed. During an interview on 4/20/17 at 8:45 a.m., staff member L stated that urinals were changed weekly by the night shift and would be changed anytime if the urinal was soiled. Staff member L stated the urinal should be dated and labeled with the resident's name and room number. Staff member L said after a resident uses the urinal, the contents should be dumped in the toilet, and the urinal rinsed with water and dumped in the toilet. Staff member L stated the urinal should then be bagged and stored in the bottom drawer in the resident's room. A urinal had been used for resident #22 for 5 weeks before being replaced. It had not been rinsed and stored in a manner that would minimize odor. The floor had not been cleaned in a manner that would minimize odor until 4/19/17. There was minimal odor in the room and bathroom on 4/20/17, after the urinal was changed and the floor was cleaned. - FALL MAT/DRAPES During an observation of room 105 on 4/17/17 at 9:26 a.m., there was an alarmed fall mat on the floor with dirt and debris visible, including two raisins that were adhering to the mat. Three pest traps were on the floor. During an observation on 4/17/17 at 4:20 p.m., the raisins had not been removed from the alarmed fall mat in room 105, and several reddish brown spots were noted on the drapes. During an observation on 4/18/17 at 7:30 a.m., the raisins were observed on the alarmed fall mat in room 105 again. The drapes continued to have the spots on them, which were initially observed on 4/17/17. During an observation on 4/19/17 at 4:30 p.m., the alarmed fall mat in room 105 had been replaced, but had remained soiled for at least 48 hours. The drapes with the soiled spots had not been changed. Review of a document titled, (Housekeeping Contractor) Housekeeping In-Service, undated, had a subject: 5-Step Daily Patient Room Cleaning. The document showed the following steps:

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

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F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 4. Dust Mop, The entire floor must be dust mopped . and Move all furniture to dust mop. At step 5. Damp Mop, The most important area of a patient's room to disinfect is the floor. This is where most air-borne bacteria will settle and so it needs to be sanitized daily. - BATHROOMS During an observation of room 105 on 4/17/17 at 9:26 a.m., there was a basin containing food wrappers, crumbs, and used tissues on the over-bed table. In the shared bathroom, on the floor, was a bedpan, a used glove, and used tissue. During an observation on 4/17/17, the shelf in the shared bathroom for rooms 300 and 301 had chunks of a white pasty substance and white streaked areas, where a liquid had dried. There was a urinal, dated 3/14/17, hanging from the towel bar. During an observation on 4/17/17, during the initial tour, in bathroom 306 was a mug, with a dried white substance and dust in the bottom, containing toothbrushes. On the bathroom shelf was a tan sticky substance, and on top of that, a piece of dycem. There was a storage container on the floor, and on top was a soap dish with a soiled gray/brown buildup in the dish. There were two non-slip strips on the floor in front of the toilet, soiled with loose dirt and debris. Hair and lint was adhered to the strips. During an observation on 4/17/17, room 307/308 was noted to share a bathroom which had a dried yellow/brown substance on the baseboard and floor. Dirt was visible on the floor, and a brown matter was adhering to the inside and rim of the toilet. Review of a document titled, (Housekeeping Contractor) Housekeeping In-Service, undated, showed a heading, titled 7-Step Daily Washroom Cleaning with two of the following steps listed (not all inclusive): 3. Dust Mop Floor 7. Damp Mop Floor. 2. Review of resident #7's Significant Change MDS, with an ARD date of 3/14/17, showed the resident was severely cognitively impaired. The MDS showed the resident was an extensive two person assist with bed mobility and toileting. During an observation on 4/17/17 at 9:15 a.m., resident #7 could answer yes and no questions by shaking her head yes or no, or blinking her eyes. The resident was not able to move herself in her bed and was not able to communicate verbally. During an observation on 4/17/17 at 9:15 a.m., in resident #7's room, the bedside table and the recliner had several pink basins with toiletries and wound care supplies. The recliner had pillows and blankets piled on the seat. The red clock on the wall was set an hour behind. There was a mouse trap on the resident's window sill and dead insects and trash behind her bed. The garbage bin was half full, and there were used gloves on the floor by the garbage can as well as used, open alcohol wipes on the floor. There was a metal walker with a tray folded up and tucked beside the recliner. The two drink holders had a large amount of crumbs and a thick brown, black food and dried liquid buildup with a white fuzzy top on the dried liquid. The resident's shared bathroom had a toilet riser with the handles duct taped with a turquoise colored duct tape, and the tape was frayed and hanging off from the left handle. During an observation on 4/18/17 at 9:20 a.m., resident #7's bedside table and the recliner had several pink basins with toiletries and wound care supplies. The recliner had pillows and blankets piled on the seat. The red clock on the wall was set an hour behind. There was a mouse trap on the resident's window sill. The metal walker had two drink holders which had a large amount of crumbs and a thick brown, black food and dried liquid buildup with a white fuzzy film on top of the dried liquid. A review of the facility's Night shift Wheel Chair Wash List showed resident #7's chair and walker was to be cleaned on the first Thursday of the month. During an interview on 4/17/17 at 12:30 p.m., staff member Q stated the housekeeping was responsible for cleaning the horizontal surfaces, floors and bathrooms. He stated there was a 5-step procedure for the resident rooms and a 7 step procedure for the resident bathrooms. Staff member Q stated it was the responsibility of the aides to clean up the clutter in the resident's rooms. He stated it was the aides responsibility to wash the resident's wheelchairs and walkers when dirty. During an interview on 4/17/17 at 4:41 p.m., staff member V stated night nurses were responsible for cleaning the wheelchairs and walkers. Staff member V stated both nursing and CNAs were responsible to clean up clutter and put away items in the resident's rooms. During an interview on 4/17/17 at 10:00 a.m., staff member A stated resident #7 had not used her walker since her readmission on 3/8/17. She stated the resident had a stroke and had not been able to use the walker since returning to the facility. Staff member A stated to leave the walker dirty in the resident's room was an oversight. She stated it was the responsibility of the nursing staff to daily clear clutter and put personal hygiene items away for the residents who needed assistance. During an interview on 4/18/17 at 2:45 p.m., staff member B stated she cleaned resident #7's room. Staff member B stated she still needed to get the broom from housekeeping to sweep resident #7's room. Staff member B stated she had changed the time on the clock. This was noted after the facility was made aware of the cleanliness concerns, which the facility had not identified and corrected prior. 3. During an observation of resident bathrooms on the 100 hall on 4/17/17 at 9:45 a.m., the following was observed: - Room 108: There was a strong odor of urine. The floor had yellow staining, and a medium sized yellow spot by the toilet was sticky when stepped on. Review of the facility grievance book showed a resident had concerns on 2/13/17, with an adjoining bathroom for room 518. The grievance was about the cleanliness of the bathroom. 4. During observation of resident bathrooms on the 500 hall on 4/18/17 at 7:15 a.m., the following was observed: -Rooms 504 and 505 had a shared bathroom. There was a strong urine odor. There was a brown substance around the edges of the floor, surrounding the toilet that extended 4 up the wall. There was a blue bed pan sitting on a plastic bag, under the sink. -Rooms 511 and 512 had a shared bathroom. There was a strong, unidentifiable odor. The floor was sticky. The toilet had a brown substance on the seat and the back. The edges of the floor, in front of and behind the toilet, were soiled with a gray and brown substance. -Rooms 513 and 514 had a shared bathroom. There was a brown substance on the slip strips located in front of the toilet. The floor was stained with a gray substance around the edges and 4 up the wall. There was food debris on the fall mat, and the floor of room 514. During an observation on 4/18/17 at 9:00 a.m., resident bathrooms in 504/505, 511/512 and 513/514 remained unchanged following cleaning. During an interview on 4/19/17 at 8:35 a.m., staff member O stated a deep clean was completed on one room, daily.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise care plans with resident condition changes for 3 (#s 3, 16, and 22) of 26 sampled and supplemental residents. Findings include: 1. Resident #16 was admitted to the facility on [DATE], and had [DIAGNOSES REDACTED]. During the initial tour of the 100 and 300 units on 4/17/17, staff member F stated resident #16 previously had a pressure ulcer which had healed prior to 4/17/17. During a record review of resident #16's, of evaluation forms titled, Weekly Pressure Ulcer BWAT Report, showed resident #16 was admitted to the facility on [DATE] with a Stage II pressure ulcer to the right buttock and the wound was documented to be resolved on 4/4/17. During an interview with staff members B and F on 4/20/17 at 10:40 a.m., staff member F stated the resident's care plan showed a current ulcer, and to her knowledge, resident #16 did not currently have a pressure ulcer. Staff member B said the ulcer reflected in the care plan was the ulcer that was present on admission and had recently resolved. Staff member B stated the care plan should have been updated to show the ulcer was resolved. 2. Resident #22 was admitted to the facility on [DATE], and had [DIAGNOSES REDACTED].

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) During an observation and interview with resident #22 on 4/18/17 at 4:30 p.m., the resident was observed to have a Foley catheter. During an interview on 4/20/17 at 9:40 a.m., staff member G stated resident #22 had both a suprapubic catheter, which was currently plugged, and a functional Foley catheter. Review of resident #22's surgical procedure report, dated 7/15/16 from (local hospital name), showed the plan for the resident was to maintain both a suprapubic and a Foley catheter. Review of resident #22's pharmacy treatment order sheet, showed an order dated 4/6/17 to change the Foley catheter. Review of resident #22's care plan showed the use of a suprapubic catheter was addressed under three focus areas: ADL deficit, Potential for skin integrity impaired, and Potential for infection. The care plan did not show the suprapubic catheter was plugged. The care plan did not show use of the Foley catheter or need for care of the catheter. During an interview on 4/20/17 at 10:40 a.m., staff member F stated she expected resident #22's care plan to show the suprapubic catheter was plugged, and the Foley was in place. She stated she could not locate the information on the care plan. 3. Resident #3 was admitted on [DATE], and had [DIAGNOSES REDACTED]. During an observation and interview on 4/18/17 at 7:30 a.m., staff member H assisted resident #3 by positioning her wheelchair at the foot of the bed as the resident sat up in preparation for a transfer. Staff member H stated the resident did not have a cushion and preferred a folded chuck in her wheelchair as padding. During an observation and interview on 4/18/17 at 2:20 p.m., a folded chuck was observed on the seat of resident #3's wheelchair. Staff member I stated the resident used this as padding, and a cushion was not used in the wheelchair. Resident #3 said she used the chuck as padding, and she didn't know anything about having a cushion. Resident #3 stated that a cushion might be more comfortable and she would try one, if offered. Review of resident #3's Care Plan, showed a focus for Potential skin integrity impaired . with an intervention of pressure reducing device: cushion to bedside chair and/or wheelchair. During an interview on 4/19/17 at 9:45 a.m., staff member F stated she relied on staff member B to inform her of which residents had wheelchair cushions. She stated she did not always confirm the information prior to completion of the MDS/CP. She said the coding was incorrect for resident #3. A review of the facility policy, titled Comprehensive Plan of Care, showed the following in the Rational section of page one: The care plan was re-evaluated and modified: - As necessary to reflect changes in care, service and treatment; - Quarterly with assessment; and - With significant change of condition assessment.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to keep resident clothing free of food debris and urine, and failed to provide grooming and facial care for 4 (#s 7, 9, 10 and 19) of 26 sampled and supplemental residents. Findings include: 1. Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of resident #7's Significant Change MDS, with an ARD date of 3/14/17, showed the resident was severely cognitively impaired. The MDS showed the resident was an extensive two person assist with bed mobility and toileting. The MDS showed the resident was incontinent all the time of bowel and bladder. During an observation on 4/17/17 at 9:15 a.m., resident #7 was laying on her back in bed. She was wearing a pink cotton shirt. The bed sheet under the resident's back was wet up to the shoulder. There was a slight odor of urine. During an observation on 4/17/17 at 4:18 p.m., resident #7 was laying on her back in bed. She was wearing the same pink cotton shirt. The bed sheet was no longer wet. There was no odor. The resident's right hand was at her side. The right hand was slightly contracted, and a strong foul odor emanated from the right hand. During an interview on 4/19/17 at 1:43 p.m., staff member B stated she did smell resident #7's right hand, and it smelled bad. She stated she cleaned the right hand with warm soap and water and moved the fingers. She stated the fingers opened without effort, and noted a small amount of stiffness in the thumb. The staff member stated there was no fingernail impressions in the palm of the hand or open skin on the palms. During an observation on 4/18/17 at 7:24 a.m., resident #7 was awake laying on her back in bed. She was wearing the same pink cotton shirt she was wearing the day before. The resident had dried drool down her right chin. She had dry and crusted eye drainage caked on the right eye, and thick creamy dark brown drainage at the corners of her mouth. During an observation on 4/18/17 at 7:28 a.m., staff member T brought the resident breakfast. She offered breakfast to the resident, and the resident shook her head no. The staff member left resident #7's room at 7:30 a.m. The staff member did not offer to wash the resident's face, hands, or change her clothes. During an observation on 4/18/17 at 8:02 a.m., staff member T returned to the resident's room, and offered the resident breakfast again. The resident shook her head no. The staff member left the resident's room, she did not offer to wash her face, hands, or change her clothes. During an observation on 4/18/17 at 8:35 a.m., staff member L cleaned the resident's face with a warm washcloth. She did not change her shirt, or wash her hands. During an observation on 4/18/17 at 9:03 a.m., the resident was laying on her back in bed. She was wearing the same pink cotton shirt from the day prior. Staff member B and staff member U changed resident #7's wet soiled brief. The wet brief had saturated the resident's bedding from below the knees to above the elbows. The bedding was changed at the same time the staff changed the resident's brief. The staff members did not change the resident's shirt and did not clean her skin after laying in wet soiled linens. During an interview on 4/18/17 at 10:00 a.m., staff member B stated she did not change the resident's shirt when she changed the urine soaked sheets. She stated it would be the expectation to change any saturated clothing, although this had not occurred. During an interview on 4/18/17 at 10:35 a.m., staff member H stated she had not been able to check on resident #7 to change her position in bed because the day was crazy. The staff member stated she had changed the resident's head of bed a couple of times from 35 degrees to 90 degrees. The staff member stated she changed resident #7's briefs, washed her face, and brushed her teeth between 7:15 a.m., to 7:30 a.m. on 4/18/17. The staff member did not mention if she cleaned the resident's hands or changed her shirt. During an interview on 4/18/17 at 11:07 a.m., staff member A stated it was the expectation of staff to change a resident's soiled clothing, and per the resident's preference, wash hands, face, and perform ADL's. During an observation on 4/18/17 at 11:30 a.m., resident #7 was lying in bed on her back wearing the same pink cotton shirt she had worn when the sheets were saturated with urine the day prior. During an observation on 4/18/17 at 12:39 p.m., resident #7 was sitting in her wheelchair, in the dining room being assisted with her lunch. She was wearing a green velvet shirt and pants. 2. Resident #19 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. [DIAGNOSES REDACTED]. During an observation on 4/17/17 at 3:40 p.m., resident #19 was seated, in his wheelchair, near the 100 hall nursing station. The tan colored hat he was wearing was noted to have soiled streaks and spots. He was not wearing any glasses. Attached to the wheelchair was a black 4-point seating system that buckled low across the waist. During an observation on 4/18/17 at 8:00 a.m., resident #19 was seated, in his wheelchair, near the nurse's station. He was wearing the same hat with the soiled streaks and spots as seen on 4/17/17. He was not wearing any glasses. During an observation on 4/19/17 at 8:10 a.m., resident #19 was seated, in his wheelchair, near the nursing station while a staff member worked on the wheelchair. Resident #19 was wearing a long-sleeved tee shirt which had loose debris/crumbs and dried matter on it. He was wearing gray jogging pants which had loose debris/crumbs on them. He was wearing the same hat with the discolored areas and spots noted on the previous day. He was not wearing any glasses.

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F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) During an observation on 4/19/17 at 2:05 p.m., resident #19 was seen with the same soiled hat and clothing as during the observation that morning. Debris/crumbs were seen on his shirt and pants, and the shirt had four discolored areas. He was not wearing any glasses. The glasses were observed on the bedside stand in the resident's room at 2:04 p.m. During an observation on 4/20/17 at 8:33 a.m., resident #19 was seated, in his wheelchair, near the nursing station. He was wearing the same soiled tan hat. His shirt had discolored spots and loose debris/crumbs on it. Loose debris/crumbs were seen on his pants. He was wearing his glasses. Discolored areas and spots were on the seating system. There was dirt on the wheelchair frame and the wheels had white spots and dirt on the spokes. The left front wheel was nearly covered with white spots and streaks. During an interview with resident #19 on 4/19/17 at 8:10 a.m., the resident looked at the surveyor but made no response showing he understood. He was unable to make himself understood. During an interview on 4/19/17 at 2:00 p.m., staff member M stated resident #19 needed staff to provide his ADL's and that he had behaviors, such as removing and twisting his glasses, and grabbing the arm of staff who were attempting to provide care. Review of resident #19's Annual MDS, with an ARD of 3/21/17, showed the need for extensive assistance of one person for dressing. The resident was coded as sometimes understood and as rarely understands. There was no cognitive score, but the assessment was coded showing the BIMS could not be conducted due to resident #19's inability to make himself understood. Review of resident #19's care plan showed a focus area of Altered ADL - Self Care Deficit, with a date of 4/25/16, which listed multiple factors contributing to the deficit. The focus showed these factors resulted in, Creating a risk for unmet needs, impaired integument (skin) and further decline. The goal showed that (resident #19) will be appropriately groomed & dressed, evidenced by neat and clean appearance; no odor. Interventions showed extensive assist of one person for dressing. 3. During an observation on 4/17/17 at 11:30 a.m., resident #10 had dried food around her mouth, and her chin was covered in facial hair. She was feeding herself with a knife. Staff did not cue her to use a fork. During an observation in the dining room on 4/17/17 at 5:00 p.m., resident #10 had dried food around her mouth. During an observation in the dining room on 4/18/17 at 7:35 a.m., resident #10 still had a chin full of whiskers, and her hair was not combed. During an observation in the dining room on 4/18/17 at 12:30 p.m., resident #10 had a dried green substance in the corner of her eyes. During an observation in the resident's room on 4/19/17 at 7:50 a.m., resident #10's clock was not set to the correct time, and her electric clock screen was flashing on and off. During an interview in 4/18/17 at 7:40 a.m., staff member J stated resident #10 could be resistive to shaving at times. 4. During an observation on 4/19/17 at 4:25 p.m., resident #9 was laying on a sheet with a large yellow-rimmed circle. The top sheet was yellowed and looked damp. He had a incontinent brief on that appeared heavily soaked. The resident stated he did not want to use his call light because They don't care. He stated all he wanted was a big towel. The room had a urine odor. Staff member N was notified of resident #9's need for a big towel. She went into the room with a towel, and immediately returned to her cart. The resident was not assisted with the soiled brief. During an observation on 4/19/17 at 5:10 p.m., resident #9 was still laying in the stained and damp-looking sheets. He had the big towel and said that it would dry things up. Staff member C was made aware of the resident's need for assistance, and said it was being taken care of. During an observation on 4/19/17 at 5:20 p.m., staff member F entered resident #9's room with a towel, and immediately came out to the hall. The sheet and soiled brief was not changed. During an interview on 4/19/17 at 5:25 p.m., staff member F stated she had asked resident #9 if he needed anything, and he stated he did not need anything. She stated she did not notice the discolored sheets or the odor.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent the development of 3 Stage II pressure ulcers, the worsening of pressure ulcers, the development of 2 Unstageable pressures ulcers, and a wound infection for 1 (#13) of 17 sampled residents. The facility failed to prevent the development of an Unstageable pressure ulcer for 1 (#6) of 17 residents. Findings include: 1. Review of the Admission MDS, with the ARD of 5/24/16, showed resident #13 came to the facility with 2 Stage II pressure ulcers. Review of the BWAT forms, dated 5/18/16, showed resident #13 had a Stage II pressure ulcer on the left gluteal fold, and 2 stage II ulcers on the left buttock. Review of the BWAT, dated 6/1/16, showed the resident's left gluteal fold ulcers had healed. Review of the BWAT, dated 6/3/16, showed the resident's new development of a Stage II ulcer to the left heel. Treatments included Rook Boots, and heel protectors. Review of the BWAT, dated 6/14/16, showed the resident's left buttock ulcer had healed. Review of resident #13's Progress Note, dated 6/16/16, showed the left heel was healing well. Review of the BWAT, dated 6/22/16, showed the heel had developed into an Unstagable pressure ulcer. The ulcer was covered with eschar. During an interview on 4/20/17 at 1:20 p.m., staff member B stated she did not know what had happened to worsen the heel pressure ulcer. She stated his heels were floated, and the strap on the back of his wheel chair was removed because it may have caused the blister. Review of resident #13's Progress Note, dated 6/28/16, showed NF2 had requested the appointment for the foot doctor on that day. Review of resident #13's Progress Note, dated 8/3/16, showed (Family member) continues to want to go to resident's podiatrist. During an interview on 4/11/17 at 1:30 p.m., NF2 stated she had to fight to get the facility to send resident #13 to the foot doctor. Review of resident #13's Progress Note, dated 8/17/16, showed out to (Podiatrist) yesterday. Continuing with [MEDICATION NAME] washes. Review of resident #13's physician order, dated 8/24/16, showed must wear boot we dispensed last week to protect heel. During an interview on 4/11/17 at 1:15 p.m., NF2 stated the boots were not on resident #13 during visits. Review of the resident's Physician Order, dated 9/2/16, showed Boot to off-weight heel to be worn at all times. Grey boot goes on L foot. Review of the resident's Progress Note, dated 10/4/16, showed Left heel has been grafted and has a non-removable dressing in place. Has specialty mattress, heel pro, and heel lift boots. Review of the resident's Progress Note, dated 12/18/16, showed the resident was sent to the ER related to a fall out of bed. Review of the resident's Hospital Notes, dated 12/19/16, showed resident #13 had Right heel has intact bullous lesion with bone palpated beneath it suggestive of suspected pressure stage 2. Left heel has dry crusted lesion with bone palpated beneath it suggestive of unstageable suspected pressure ulcer. During an interview on 4/21/16 at 1:20 p.m., staff member B stated she had not looked at resident #13's heel, since 11/8/16. She was not aware the pressure ulcer was still on the heel. 2. Review of resident #13's Progress notes showed he discharged from the facility on 7/12/16, with a UTI, and readmitted on [DATE], with a Stage II pressure ulcer on the sacrum, and an Unstageable area on the left buttocks. Review of the Progress Notes for resident #13, dated 7/27/16, showed the left buttock was now a Stage II, and the sacrum remained a Stage II. Review of the Progress Note, dated 8/10/16, showed resident #13's left buttock ulcer had healed, and the pressure ulcer to the sacrum running across both buttocks, had resolved. Has (new) abrasion to left buttock that appears to be from armrest of chair when transferred with mechanical lift.

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	275030	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE & REHAB - PARK PLACE	1500 32ND ST S GREAT FALLS, MT 59405

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) Review of the resident's Progress Note, dated 9/6/16, showed the abrasion to the left buttock continued. An abraded area was also noted to the scrotum, and some excoriation, lower down the left buttock. During an interview on 4/20/17 at 4:25 p.m., staff member B stated the open areas were identified as injuries, and not pressure ulcers. She stated the treatment would not have changed if the areas had been identified as pressure. Review of the resident's physician's orders [REDACTED]. Review of the resident's Progress Note, dated 11/1/16, showed bilateral buttocks are very macerated. Skin is white and peeling away. Believe this is from too much moisture with current treatment. Some bleeding noted. Right buttock measures 4.3 x 3.2 cm, and left buttock measures 5.9 x 3.8 cm. Will request orders for [MEDICATION NAME] q shift and to wear tape attends products to assist with moisture issues. Review of the resident's Progress Note dated, 11/8/16, showed [MEDICATION NAME] noted at 50% of wound bed. Scrotal area with new skin damage. Has appearance of being torn, maybe by adjusting of attends or pants. Scabbed over. Will continue use of antifungal powder/Vaseline mix to soften scab. Resident continues to be non-compliant with turn and repositioning. Review of resident#13's Significant Change MDS, with the ARD of 10/18/16, showed the resident required extensive assist of two people to reposition in bed. Review of the resident's Progress Note, dated 11/14/16, showed Injury to left ischium and across to scrotum covered with necrotic tissue now. Unable to use tape on this resident as his skin reacts. MD notified and that wound has progressed and is now a pressure ulcer. Have PT to debride and treatment. Airbed orders and will be delivered within 24 hours. Review of the last physician visit provided by the facility, dated 11/14/16, showed the resident had Fever above 102 several days. New decubitus of buttocks. Culture if temp. A review of resident #13's Progress Note, dated 11/15/16 showed he had a temperature of 100.2. Review of resident #13's Progress Note, dated 11/20/16, showed a new open area on the coccyx. Review of resident #13's Wound Clinic Report, dated 11/29/16, showed an Unstageable pressure ulcer of the left buttock. Review of resident #13's Progress Note, dated 12/1/16, showed he was now being treated at the wound clinic. Review of resident #13's Progress Note, dated 12/4/16, showed, Resident appetite poor @ lunch. Lethargic @ times & slow to respond to staff questions .temp decreased to 98.4 with prn Tylenol Review of resident #13's Progress Note, dated 12/5/16, showed IDT review r/t fall out of bed this past weekend. Resident is on air mattress with a low bed. This is an isolated incident. Resident was running an increased temperature and more lethargic than usual. ? (sic) infection r/t wound. Will have MD assess resident. During an interview on 4/20/17 at 2:50 p.m., staff member K stated resident #13's wound care was managed by the wound clinic, when asked about wound cultures for non-healing pressure ulcers. Review of resident #13's Wound Clinic Report, dated 12/6/16, showed the left buttock wound site was larger, with a new sacral ulcer; Stage III. Review of resident #13's IDT note, dated 12/8/16, showed injury with added pressure to sacrum to ischium. Wife continues to place an extra cushion in wheelchair under ROHO (a cushion). Education provided but she continues to direct and provide husbands care. Wound is followed by wound clinic. Wound is worsening. Resident is up for meals only. During an interview on 4/20/17 at 1:40 p.m., staff member B stated she had never personally seen the wife place the cushion on the chair. During an interview on 4/11/17 at 1:35 p.m., NF2 stated she visited resident #13 on 12/11/16, and he did not appear to be his usual self, and did not eat or speak much. Review of resident #13's Progress Note dated 12/15/16 showed the Foley catheter was blocked. New catheter inserted using sterile technique, balloon inflated with 8cc sterile water, 900 cc dark cloudy fluid return. Afebrile. During an interview on 4/18/17 at 1:00 p.m., staff member E stated she notified the physician by putting the above note in the MD book. No further documented assessment was completed for the resident's temperature, wound or urinary status. Review of resident #13's Vitals tab, in the electronic record, showed no temperature had been recorded since 12/8/16. During an interview on 4/20/17 at 8:40 a.m., staff member A stated there was nothing going on with the resident to warrant recorded temperatures. 3. Resident #13 was discharged to the hospital on [DATE], after a second fall out of bed. Review of resident #13's ER admission note, dated 12/18/16 at 1:43 a.m., showed (physical exam in the ED has revealed what I can only describe as significant neglect resulting in serious ulceration, possible perirectal fistula and even ulceration and swelling of the posterior scrotum. There was stool packed into his wounds. His urinalysis shows significant infections. Skin break down was noted on both heels, pressure sore with damage down to the fascia on the scrotum and pressure sore on coccyx with damage down to the muscle. Review of the resident's hospital notes, dated 12/25/16, showed the resident had septic shock secondary to urinary tract infection present on admission; stage IV decubitus ulcer, which was noted to have stool inside the wound at admission. A culture, dated 12/19/16, showed drainage from the penis had E. coli, and Proteus Mirabilis. The two urine cultures were contaminated with the same 2 organisms. The left ischial necrotic tissue had the same two organisms, plus Pseudomonas aeruginosa. The bone culture also had [MEDICAL CONDITION][MEDICATION NAME]. Resident #13 had surgery for [REDACTED]. He was placed on Hospice 12/28/16. The resident passed away on 12/29/16. 4. Review of resident #13's Progress Note, dated 6/22/16, showed his penis was swollen and macerated. Review of resident #13's Progress Note, dated 6/22/16, showed he had a small amount of thick green drainage from the open area on the penis. Will request orders for antibiotic ointment. During an interview on 4/19/17 at 3:00 p.m., staff member B stated she determined the open area was an injury related to the Foley catheter and resident rubbing penis back and forth. She stated it did not look like a pressure ulcer, and she determined it as an injury. Review of resident #13's Progress Note, dated 6/29/16, showed Catheter is rubbing penis and causing drainage. Review of resident #13's Physician order, dated 7/19/16, showed Apply [MEDICATION NAME] BID to open area of penis. Review of resident #13's electronic record showed the resident was discharged to the hospital on [DATE] for a urinary tract infection. Review of resident #13's physician progress notes [REDACTED]. Review of resident #13's Progress Note, dated 10/18/16, showed he continued to have an open area to foreskin. Staff report continued stimulation to area. Resident denies manipulation. Review of resident #13's Progress Note, dated 12/18/16, showed he fell out of bed on his face. He was taken to the ER. Review of the resident's Discharge summary from the hospital, prior to admit to ICU, at a second hospital, showed pus in the Foley catheter and around the urethral meatus. There was a small skin ulceration with pus at the foreskin area. During an interview on 4/20/17 at 8:45 a.m., regarding the UTI and pus, staff member A stated the facility could not be responsible for what happens at the hospital. During an interview on 4/20/17 3:40 p.m., staff member D stated resident #13 fell out of bed. She sent him to the ER. She could not remember whether he had a boot on (for wound). She thought the staff took vitals, but they were not recorded. She did not notice anything out of the ordinary. 5. Resident #6 was admitted with [DIAGNOSES REDACTED]. Review of resident #6's Quarterly MDS, with an ARD of 3/3/17, showed the resident had a BIMS of 6, showing severely impaired cognition. The Quarterly MDS showed the resident was a two-person extensive assist for bed mobility and total dependence for toilet use. The MDS showed the resident was always incontinent of bowel. The Quarterly MDS showed the resident was a high risk for pressure ulcers and had a unhealed pressure ulcer noted on the last OBRA. The Quarterly MDS showed there were no current pressure ulcers for the resident. Review of resident #6's most current Braden scale showed the resident was a high risk for pressure ulcers. During an observation on 4/19/17 at 3:43 p.m., staff member L told staff member B resident #6 had a new red open area on his coccyx. During an observation on 4/19/17 at 4:49 p.m., staff member B performed wound care to resident #6's coccyx and back. The area was approximately 1 cm by 1 cm of reddened tissue with approximately 50% slough and open in center with a dark red dot in the middle. During an interview on 4/19/17 at 4:49 p.m., staff member B stated the area on the coccyx was a new pressure ulcer, and she would put the resident on pressure ulcer precautions, and get an order from the physician. Staff member B stated she was

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) just notified of the skin change on resident #6's coccyx. Staff member B stated she had not been informed of any skin changes for resident #6 prior to this wound care. Review of resident #6's CNA Skin Observation documentation record, from 4/1/17 to 4/19/17, showed red area, documented on the following dates, but there was no indication on the CNA documentation record of where the red area was noted: - 4/8/17 - 4/9/17 - 4/10/17 - 4/11/17 - 4/14/17 - 4/15/17 - 4/16/17 - 4/17/17 - 4/19/17 Review of resident #6's Weekly Skin Check, dated 4/14/17, showed heels are clear, coccyx is reddish but CR is STAT. Turned to side with pillows placed to avoid pressure on coccyx. Skin warm and dry turgor good no tenting. This was a new area of redness and was not indicated as such on the Weekly Skin Check sheet. Review of patient #6's nursing notes did not show any further skin assessments to check the reddish area on the coccyx and the wound care nurse was not notified of the change to the resident's skin until 4/19/17. Review of resident #6's Weekly Pressure Ulcer BWAT Report, dated 4/19/17 showed, Weekly Pressure Ulcer BWAT Report Completed. Site information: Coccyx-Pressure: Length 0.5, Width 0.5, Depth, unstageable. Date of initial observation: 4/19/17. BWAT score 28.0. See progress note assessment for more details. Noted new open area to coccyx, Measurements are 0.5 x 0.5 with yellow center that covers approximately 50% of the wound. Unstageable. secondary to slough. there is no odor, no drainage, and no surrounding redness noted. Painful to touch. Will request new orders for ulcer care to area change Wednesday and Saturdays. Ulcer care placed. Will update guardian and MD in AM. Will place ROHO as soon as one available. Request pain medication prior to treatment. Refer to dietary. Turn and reposition per plan. During an interview on 4/20/17 at 11:34 a.m., staff member K stated the CNAs Skin Observation Documentation record, did not allow the CNAs to make a note to where the red area was observed. She stated it would be the expectation of the CNAs to let the floor nurse know of any new findings to the resident's skin. It would then be the nurse's responsibility to monitor the patient's skin for changes, and notify the wound nurse of any new areas of skin breakdown or ulceration. Staff member K stated it was the expectation of staff to notify the wound nurse as soon as the area was noted. The nurse would make a note in the Weekly Skin Check which would indicate the area is new and this alerts the wound nurse. Staff member K stated the weekly skin check on 4/14/17 should have been noted in the documentation as a new area, and it was not. During an interview on 4/20/17 at 12:00 p.m., staff member B stated she was not notified of the skin change to resident #6's coccyx. She stated had she been notified of the change, she would have assessed the area immediately and implemented an appropriate treatment. The staff member stated, had she not been available, there was a secondary nurse that could be notified for wound management on the weekends.
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to identify the root cause and analyze risk factors to prevent falls with injury; failed to implement interventions, monitor for effectiveness, and modify interventions as needed for 2 (#9 and #13) of 17 sampled residents. Findings include: 1. Review of resident #9's Quarterly MDS, with the ARD of 12/8/16, showed he required supervision and 1 person assist for transfers, and was cognitively intact. Review of resident #9's Care Plan, dated 5/20/14, showed he had a recent fall with fractures, was non-weight bearing, and had poor safety awareness. The interventions included: check ammonia levels if altered mental status is present; Ensure brake extensions are in place to wheelchair; Ensure fridge is stocked to decrease risk for falls; Monitor, cue as needed and minimize clutter. Review of the resident #9's Care Plan, dated 2/27/17, showed Impaired communication, cognition and impaired thought process related to exhibits poor safety awareness, impulsive actions, requires frequent verbal cues for safety and care needs, hearing impaired, forgetful, and easily confused. (Resident) inconsistently uses his call light due to cognition. Review of resident #9's Post Fall Investigations reports showed 13 unwitnessed falls from 4/16/16 through 4/17/17. The 12th fall resulted in a non-displaced trochanter fracture and right inferior pubic ramus fracture. Review of resident #9's Post Fall Investigation, dated 4/16/16, showed he slipped on the skid strips (used to prevent falls.) He stated he was using the urinal and got dizzy. He stated his pain was at a 10 and his knees gave out on him. The intervention implemented was Physical Therapy from 4/19/16 through 6/7/16. The dizziness was not addressed. Review of resident #9's Post Fall Investigation, dated 6/16/16, showed he was found in the bathroom, sitting upright. There was feces on the floor and he had poor footing while walking. Contributing causes included non-compliance. No documented interventions were implemented to prevent further falls. Review of resident #9's Post Fall Investigation, dated 7/15/16, did not describe the fall, but showed he was found in his room, laying on his back, with legs stretched outward, next to his bed. No investigation or analysis was completed regarding the cause of the fall. Review of resident #9's Post Fall Investigation, dated 8/23/16, showed he was sitting on the floor, on his bottom, with his back against the bed. He stated he dropped his medications on the floor and was bending over to pick them up. He had a red bruise/abrasion between his brows and tender to touch. No new interventions were implemented; interventions in place were not evaluated for effectiveness. Review of resident #9's Progress Note, dated 8/29/16, showed he had a fall out of bed, trying to find his cell phone. A Fall Investigation report was not provided. The new intervention was to place a call sign to remind resident to call before reaching items. During an observation on 4/18/17, 4/19/17 and 4/20/17, no sign was visible in resident #9's room to remind the resident not to reach for items without calling for assistance. Review of resident #9's Post Fall Investigation, dated 9/01/16, showed the resident was lying on his back, 5 to 7 feet away from the bed. He was reaching for a coke from the refrigerator in his room. His pain level was a nine. No further analysis was completed for a root cause for the fall, or new interventions. Documentation showed, Resident has fallen 6 times since March. Will monitor. The monitoring was not measurable, or clear enough to show what staff were to monitor for. Review of resident #9's Post Fall Investigation, dated 10/24/16, showed the resident was found in the bathroom, on the floor, with his call light on. I slipped in these socks. Review of an IDT note for resdent #9, dated 10/27/16, showed Resident reminded to either wear non-skid socks or shoes during ambulation. Although the resident did not have good recall for calling for assistance, staff continued to use the intervention to remind the resident. Review of an IDT note for resident #9, dated 12/20/16, showed review related to fall last week. Resident slid off the edge of bed while trying to get to bathroom He has non-skid strips beside bed and slippers with good soles. He was incontinent of bowel and appears to have slid in it (feces). Resident is independent with ambulation. Isolated incident. No further interventions needed. No Post Fall Investigation was provided. The facility did not address the resident's potential need for more assistance relating to bowel and bladder deficits. Review of resident #9's Post Fall Investigation, dated 12/22/16, showed the resident was found on the floor of his bathroom, and stated he lost his balance. A contributing cause was listed as non-compliance. The loss of balance was not addressed. Review of resident #9's Post Fall Investigation, dated 1/10/17, showed a CNA found him lying on the floor. He stated he was looking for stuff in the bottom of his closet and I got dizzy. Review of resident #9's IDT note, with no date, showed a review of the 12/22/16, and 1/10/17 falls: Resident is independent

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F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 6) with ambulation in room. Does use walker. Nonskid strips beside bed and in bathroom. Room was changed to allow easy access to his fridge and other items he uses frequently. Resident has a history of balance issues which does affect him when bending down or reaching for items, causing a loss of balance, resulting in a fall. PT has worked with resident in the past with good results. Takes Meclizine for dizziness. Resident will call for assistance if not feeling well but not for simple tasks that he believes he can do on his own. Plan: therapy to review Berg Balance Scores from recent therapy session to see if an improvement in noted with therapy if balance remains unchanged. Will review to determine if further therapy is indicated. The IDT note, addressed factors from the 12/22/16 fall that may have prevented the fall from occurring on 1/10/17, but the IDT did not address these until after 1/10/17, which was at least 20 days after the 12/22 fall. During an interview on 4/20/16 at 8:20 a.m., staff member A stated PT was initiated for resident #9 on 1/13/17. Review of resident #9's Post Fall Investigation, dated 2/10/17, showed he was found sitting on the floor by the bed. He stated he was walking back to his bed from the bathroom. A team huddle (IDT huddle meeting and discussion) was documented after the fall, but no analysis, root cause, new interventions, or evaluation of the effectiveness of current interventions was documented in the resident's medical record. Review of resident #9's Post Fall Investigation, dated 2/19/17, showed he was found on his back, his feet toward the bathroom door, head against his hallway door, and he was incontinent of bowel and bladder. A contributing cause was listed as non-compliance. Review of resident #9's Progress note, dated 2/27/17, showed he had sustained two fractures from the fall on 2/19/17; a hip and pelvic fracture. The resident was now non-weight bearing. Review of resident #9's Significant Change MDS, with the ARD of 2/27/17, showed he now required two person extensive assist with all his ADLs except for eating. A Foley catheter was placed for bladder incontinence related to immobility. During an interview on 4/17/17 at 1:00 p.m., resident #9 stated he stayed in bed now, and did not get dressed. He said he would shower if he wanted. He said he was now afraid of falling. I fell , and I fell , and I fell . He stated he didn't use his call light because They don't care about me. During an interview on 4/20/17 at 8:40 a.m., staff members A and C stated the facility did have a fall prevention program in place, and that team huddles were conducted with each fall. The team huddle answered the 10 questions (for falls) to determine the root cause. Staff member C stated the facility did not keep this document, because it was a working tool, therefore the root cause analysis was not documented in the resident's medical record. One of 15 falls had documentation from the team huddle for resident #9's falls. Staff member C also stated the resident had the right to fall. 2. Review of resident #13's progress note, dated 5/23/16, showed a Post Fall Investigation was completed for a fall on an unidentified date. See investigation for details. No Post Fall Investigation was provided by the facility. Review of resident #13's Admission MDS, with the ARD of 5/24/16, showed he had a history of [REDACTED]. Review of resident #13's IDT note dated 5/23/16, showed a review of the falling star program (fall program). Resident is not impulsive and will call for assistance when needed. Will remove from falling star program. Review of resident #13's Post Fall Investigation, dated 12/5/16, showed he was found lying on the floor by his bed. Review of resident #13's IDT note, dated 12/5/16, showed Resident is on an air mattress with a low bed. This is an isolated incident. Resident was running an increased temperature and more lethargic than usual. ? (sic) infection related to wound. Will have MD assess resident. Review of the Physician visits for resident #13 showed no visit or assessment was completed after 11/14/16. During an interview on 4/11/17 at 1:35 p.m., NF2 stated she visited resident #13 on 12/11/16, and he did not appear to be his usual self, and did not eat or speak much. Review of resident #13's Post Fall investigation, dated 12/18/16, showed he had fallen out of bed, onto his face, and sustained a large hematoma over right eyebrow. During an interview on 4/11/17 at 1:40 p.m., NF2 said the hospital called her the night of 12/18/16, and asked Do you know how sick (resident #13) is? Review of resident #9's Progress Note, dated 12/18/16, showed he was discharged to the hospital. The resident was admitted , and the resident had an infection in the wound of the buttock. (Refer to F314) Review of resident #13's Care Plan, dated 7/19/16, showed no new interventions were implemented to prevent falls after each of the three falls. The investigations did not include the root cause analysis of the falls, monitoring, or evaluation of the resident's individualized risk factors.
F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from a significant medication error, during the administration of a rapid-acting insulin for 1 (#8) of 17 sampled residents. Findings include: Resident #8 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of patient #8's Progress Note from (hospital name), dated 4/13/17, showed: Plan: 2. Tube feeds per dietary recommendations. Free water boluses as well . 4. Sliding scale insulin. A review of resident #8's MAR, dated 4/01/17 - 4/30/17, showed: CBS TID, before meals for DM. A review of resident #8's MAR, dated 4/01/17 - 4/30/17, showed: Humalog Solution 100 unit/ml (Insulin [MEDICATION NAME]) Inject as per sliding scale: if 0-139 = 0 units; 140-199 = 1 unit; 200-249 = 3 units; 250-299 = 5 units; 300-249 = 7 units; 350-399 = 9 units; 400+ = call MD subcutaneously before meals for DM in addition to scheduled dose. A review of resident #8's MAR, dated 4/01/17 - 4/30/17, showed: Humalog Solution 100 unit/ml (Insulin [MEDICATION NAME]) Inject 10 units subcutaneously before meals for DM in addition to sliding scale. Review of resident #8's TAR, dated 4/01/17 - 4/30/17, showed: Enteral Feed Order five times a day Enteral Nutrition via Bolus: Full Strength [MEDICATION NAME] 2.0 at frequency: 250 mls 5 times day. Total mls/24 hours: 1250 mls. To be given at Hours of: 0500, 1000, 1500, 1800, and 2200. During an interview on 4/17/17 at 12:00 p.m., staff member J stated they were trying to coordinate resident #8's bolus feeding scheduled with his administration of insulin. Staff member J stated as the orders were, resident #8 would wait an hour between his bolus feedings and his Humalog insulin administration. Staff member J stated the resident should have food within 15 minutes of the Humalog insulin administration. During an interview on 4/17/17 at 3:10 p.m., staff member P stated the resident received tube feedings at 5:00 a.m., 10:00 a.m., 3:00 p.m., 6:00 p.m., and 10:00 p.m. The staff member stated she would administer the resident's tube feeding at 3:00 p.m., and would then check the resident's blood sugar between 4:00 p.m., and 4:30 p.m., and would then administer his insulin per the sliding scale. Staff member P stated the resident would receive the insulin around 4:00 p.m., and she would then administer his next tube feeding at 6:00 p.m. She stated the fast-acting insulin should be administered for the resident 15 minutes before or after his bolus feeding. The staff member stated it was difficult to work out the resident's insulin administration with his tube feeding because the tube feedings were five times daily, and the insulin was three times daily. She stated the resident was out of the facility during the day for [MEDICAL CONDITION] and [MEDICAL CONDITION]. During an observation on 4/17/17 at 3:11 p.m., staff member P administered resident #8's bolus tube feeding. During an observation on 4/17/17 at 4:00 p.m., staff member P checked patient #8's blood sugar, and administered the appropriate dose of Humalog Insulin per the sliding scale. The Humalog was administered 45 minutes after his 3:00 p.m. tube feeding, and 2 hours before his 6:00 p.m., tube feeding. ¹ During an interview on 4/17/17 at 4:10 p.m., staff member P stated she would administer resident #8's next bolus tube feeding at 6:00 p.m. Staff member P stated she was not concerned about the administration times of insulin in relation to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275030	A. BUILDING _____ B. WING _____	04/20/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE & REHAB - PARK PLACE	1500 32ND ST S GREAT FALLS, MT 59405

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 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) the resident's tube feeding times. The staff member stated it was difficult to administer the resident's insulin dosing with his tube feeding, and manage his outings for [MEDICAL CONDITION] and [MEDICAL CONDITION]. During an interview on 4/19/17 at 9:00 a.m., staff member A stated resident #8 did not have a [DIAGNOSES REDACTED]. The staff member stated it was protocol on all new tube feedings, because the enteral nutrition was so high in calories, the body couldn't manage the sugars, so any resident on a new tube feeding would receive insulin. Staff member A stated she wrote the orders for the tube feedings and the insulin administration on the MAR and TAR. She stated she was not worried about the resident receiving the insulin an hour after his bolus tube feeding and an hour before his next tube feeding, because he was not a diabetic. The staff member stated symptoms of [DIAGNOSES REDACTED] were shakiness, confusion, diaphoresis, nausea, vomiting, and [MEDICAL CONDITION]. She stated for residents who were diabetic, and received a fast acting insulin such as Humalog, it would be the procedure to administer the insulin 15 minutes before or after a meal to avoid low blood sugars Staff member A provided a Progress Note, dated 4/19/17, which reflected, Resident has order for CBS TID with scheduled and sliding scale insulin. Does not have [DIAGNOSES REDACTED]. Need clarification on when to check CBS and administer insulin with new tube feeding schedule. A review of resident #8's Medication Discharge Summary, dated 4/15/17, showed: Humalog (Insulin [MEDICATION NAME] 100 units/ml 3 ml vial. subcutaneous three times daily with meals. A review of resident #8's Progress Note, from (hospital), dated 4/6/17, showed: Assessment and plan: Diabetes Mellitus . During an interview on 4/19/17 at 10:00 a.m., resident #8 stated he was a diabetic and had been for the past [AGE] years. The resident stated he managed his diabetes at home with the daily assistance of his hospital. The resident stated he was on a long acting insulin but was taken off the [MEDICATION NAME] in the hospital and put only on Humalog. The resident stated he had been vomiting due to the [MEDICAL CONDITION] and [MEDICAL CONDITION], and had not been feeling well since he was admitted on [DATE]. Review of the facility's procedure, titled, Duration of Effect of Various Insulins When Given by Subcutaneous Injection, showed, Rapid Acting, [MEDICATION NAME] Humalog, Administer within 15 minutes before or immediately after a meal. On 4/17/17 and 4/19/17 a facility policy and procedure on insulin administration was requested, and was not provided by the facility. [1] http://pi.lilly.com/us/humalog-pen-pi.pdf INDICATIONS AND USAGE; HUMALOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. (1); 2.2 Route of Administration Subcutaneous Injection: HUMALOG U-100 or U-200. Administer the dose of HUMALOG U-100 or HUMALOG U-200 within fifteen minutes before a meal or immediately after a meal by injection into the subcutaneous tissue of the abdominal wall, thigh, upper arm, or buttocks. To reduce the risk of [DIAGNOSES REDACTED], rotate the injection site within the same region from one injection to the next (see Adverse Reactions (6)).
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed medical supplies in areas where the supplies could become contaminated for 1 (#23) of 26 sampled and supplemental residents. During an observation on 4/17/17 at 12:35 p.m., of the bathroom between rooms [ROOM NUMBERS], the sink had rubber tubing, a syringe, and a plastic measuring container on top of a washcloth on the left side of the sink counter. During an observation on 4/18/17 at 7:39 a.m., tubing, a syringe, and a measuring container sat on a washcloth on the sink counter of the bathroom between rooms [ROOM NUMBERS]. Review of resident #23's medication administration record showed the resident was receiving food and medication through a feeding tube. Resident #23 resided in room [ROOM NUMBER]. Review of the resident #25's Significant Change MDS, with an ARD of 3/24/17, showed the resident was coded for being moderately impaired; a coding of 12 on the assessment. The resident resided in room [ROOM NUMBER]. During an interview on 4/18/17 at 7:55 a.m., staff member G stated the tubing, syringe and measuring container were for resident #23. The staff member agreed the items should not be left on the sink shelf, in a bathroom shared by another resident.