| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275026 | A. Building<br>B. Wing | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ivy at Great Falls | 1130 17th Ave S<br>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.

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>46400<br><br>Based on observation, interview, and record review the facility failed to implement steps to prevent further potential abuse during an alleged sexual abuse investigation for 2 (#s 73 and77) of 2 residents sampled. Findings include:<br><br>Review of resident #73's nursing progress notes, dated 10/10/22, showed, Resident [#73] was found in another resident's [#77] room. He was sitting on her bed with his hand in her shirt. Resident was removed from the room and taken back to his own room.<br><br>Review of resident #73's medical record revealed a lack of interventions to monitor his behavior, between the time the incident occurred, and two days later while the investigation was ongoing.<br><br>Review of resident #77's medical record revealed a lack of physical or psychosocial assessment after the incident, and a lack of interventions intended to protect the resident from further inappropriate touching or abuse during the investigation.<br><br>During an interview on 10/12/22 at 3:37 p.m., staff member B stated staff was closely monitoring resident #73, as an intervention to prevent further abuse of resident #77, or any other vulnerable residents on the unit. She could not speak to any documentation or definition of this staff responsibility.<br><br>During an observation on 10/12/22 at 6:00 p.m., resident #73 walked into the wrong room, left his walker, and continued down the hallway without staff intervention.<br><br>During an interview and observation, on 10/12/22 at 6:10 p.m., staff member F stated on night shift the aides and nurse take turns doing rounds on the hour. He stated there is usually three staff on the secured unit at night, but when they are short (on available staff) there has been times where it was only two. He then showed the every 15 minute observation sheet that had been started for resident #73 on 10/12/22 at 5:00 p. m.<br><br>Review of resident #73's nursing progress notes, dated 10/12/22, and time-stamped at 6:30 p.m., showed, 15-minute checks implemented to redirect resident if necessary from entering other residents rooms.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0610<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 10/13/22 at 2:39 p.m., NF3 stated she wished there was more supervision [on the secure unit]. She stated residents continuously wander into and out of each other's rooms, and there have been times she was unable to immediately locate a staff member. |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40068<br><br>Based on observation, interview, and record review, the facility staff failed to provide timely medical care, resulting in a resident's emergency transfer to the hospital after the resident became septic, for 1 (#95) of 1 sampled resident; and the facility staff failed to follow physician orders related to catheter use, for 1 (#84) of 1 sampled resident. Findings include:<br><br>1. During an observation and interview on [DATE] at 1:37 p.m., resident #95 was lying in bed, on his back, with bilateral drains coming out of his back. The left drain was observed with purulent drainage in the drainage bulb. Resident #95 stated the drains were for an abscess that occurred after he did not receive medical care for a UTI. He stated he had a foley catheter, and the facility monitored him for symptoms of a UTI. He stated he complained a few months ago of foul-smelling urine, but the facility and doctor did not do anything about it. He stated, You could smell it clear down the hallway. He stated he almost died because he had such a bad infection, and it took the facility and doctors too long to do anything about it.<br><br>During an interview on [DATE] at 2:45 p.m., staff member E stated resident #95 had foul smelling urine and it was communicated to staff members J and K multiple times. Staff member E stated the resident was hospitalized after becoming unresponsive and septic.<br><br>Review of resident #95's nursing progress notes, dated [DATE] showed, Resident noted to have foul smelling dark yellow urine to f/c. Catheter has large amount of sediment. Notification placed in medical providers communication book.<br><br>A request was made on [DATE] at 1:45 p.m. for the medical providers communication book, but no provider communication book was received from the facility prior to the end of the survey.<br><br>Review of resident #95's nursing progress notes, dated [DATE] showed, Received new orders for mucinex, benadryl, and lidoderm patch. All orders noted. Resident continues with foul smelling urine with large amount of sediment. Received order to encourage fluids. Resident informed and upset that a urine test was not ordered because he states he already drinks large amounts of water.<br><br>Review of resident #95's nursing progress notes, dated [DATE] showed, Received new order for resident to increase fluids for abnormal urine. Resident reports 'I can't drink more water than I already do.' Resident is often observed and usually consumes ,d+[DATE] cc of water on noc shift. This writer unable to change catheter because resident had catheter change during recent hospitalization in July of 2022. Resident's urine displays s/sx of infection. Resident is afebrile. Resident was being treated for UTI prior to covid related hospitalization . It does not appear treatment cont'd during stay. NP notified and order received to increase fluids. Resident denies pain, malaise, or distress but states his kidneys may be off from blood thinner treatment while hospitalized . Currently resident in room eyes closed even and unlabored respirations. Call light and water maintained within reach.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of resident #95's nursing progress notes, dated [DATE] showed, Resident had high B/P, confusion, foul smelling and looking urine and was sweating. Phoned on call MD, and she instructed us to send to ER for evaluation because she thought he might be septic. He was picked up and transported at approximately 0745 (7:45 a.m.). Report was given to ER charge. All transfer paperwork completed and sent to ER with him. Will follow up at around 1030 (10:30 a.m.).<br><br>There was no documentation for resident #95's symptoms after [DATE], until [DATE].<br><br>Review of resident #95's Consultation Report, dated [DATE] showed, The patient is a morbidly obese, [AGE] year-old gentleman who presents with a history of incomplete paraplegia secondary to a T8-T9 myelopathy resulting in a neurogenic bladder with chronic Foley catheter placement. Recently hospitalized in July with severe COVID pneumonia. Now presenting with several days onset of malaise, not feeling well, found to be hypotensive and tachycardic in the ER with Foley catheter that had not been draining and it was exchanged and noted to have purulence draining through the catheter. Subsequent imaging demonstrated abscesses bilaterally at the [NAME] of the penis and findings concerning for Fournier's gangrene. The patient this afternoon is relatively nonverbal .The patient reports no other prior episode of perineal infection .intensivist is at the bedside also interviewing the patient .PLAN: .I therefore contacted Interveinal Radiology and we discussed bilateral drain placement to help manage his developing abscess, early Fournier's gangrene and this will be attempted later this afternoon.<br><br>The following references showed, Patients with moderate or severe clinical presentations should have empiric antimicrobial therapy initiated pending urine culture results.<br><br>The positive findings of a urine culture can lead to the diagnosis of UTI (uncomplicated versus complicated), asymptomatic bacteriuria, catheter-associated UTI, and catheter-associated asymptomatic bacteruria. These diagnoses lead to the possible identification of the source of sepsis. Proper diagnosis lends itself to proper antibiotic stewardship and decreases in morbidity and mortality . utilization of urine culture is of utmost importance to determine potential diagnosis.<br><br>https://www.infectiousdiseaseadvisor.com/home/decision-support-in-medicine/infectious-diseases/urinary-tract-infection-uti-in-the-catheterized-patient/#:~:text=When%20a%20chronic%20indwelling%20catheter%20has%20remained%20in,replacement%20catheter%20prior%20to%20institution%20of%20antimicrobial%20therapy<br><br>Most patients with catheter-acquired urinary infection are asymptomatic and identified only if a positive urine culture is reported.<br><br>https://www.ncbi.nlm.nih.gov/books/NBK557569/<br><br>2. During an interview on [DATE] at 3:36 p.m., staff member B stated resident #84 did have issues with his suprapubic catheter becoming clogged. If the nurse was unable to flush the catheter, then they should change it.<br><br>Review of resident #84's Physician orders, dated [DATE] showed, Suprapubic catheter 18FR, 10cc balloon, monitor placement and function of catheter q shift. DX: NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of resident #84's nursing progress notes, dated [DATE] showed, CNA alerted that resident was saturated with urine and that the foley cath bag hasn't had much in it for the entire day. Unable to find 18fr foley cath anywhere in facility. Removed 18fr foley with resident tolerating well and placed 16fr foley at this time. Once placed urine returned immediately. [sic]<br><br>During an interview on [DATE] at 4:48 p.m., staff member B stated the resident did not have an order for a 16fr and stated this would be a concern due to the 16fr being smaller than his ordered 18fr, and his history of having frequent clogging of his catheter tubing. |