STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275134	A. Building B. Wing	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy at Deer Lodge	1100 Texas Ave Deer Lodge, MT 59722

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45447 Based on observation, interview, and record review, the facility failed to ensure the base of the toilet and sink countertop were clean for 1 (#37) of 2 sampled residents. Findings include: During an interview on 9/13/22 at 3:06 p.m., NF1 stated on the evening of 9/12/22, she visited resident #37. During the visit, NF1 stated she observed stool on the floor and toilet of resident #37's bathroom. NF1 stated she had let a CNA know about the mess in resident #37's bathroom, then went on a walk with resident #37. NF1 stated when they returned from their walk, resident #37's bathroom was still dirty, with stool on the floor. NF1 stated she asked a CNA again about cleaning resident #37's floor, and stated the CNA stated they forgot to clean it. During an observation on 9/14/22 at 4:52 p.m., resident #37's toilet had a blue, rubber glove in the toilet bowl, the ceramic toilet water reservoir lid was partially off, and there was brown stool smeared at the base of the toilet. There was also a large, round, dark brown area around and behind the base of the toilet. Resident #37's sink top had brown stool with wadded up paper towel on the right side, and ripped paper towel to the left of the sink. During an observation on 9/15/22 at 7:41 a.m., resident #37's toilet had brown stool smeared at the base of the toilet, with a large, round, dark brown area around and behind the base of the toilet. Resident #37's sink had a toothbrush lying on the sink counter, with the bristles touching the sink top. During an interview on 9/15/22 at 8:00 a.m., staff member H stated resident #37 had a history of urinating on the floor and making messes in her bathroom. Staff member H stated housekeeping should clean the resident bathrooms at least once a day. Staff member H stated resident #37 had a new, smaller toilet put in to help her urinate in the toilet. During an interview on 9/15/22 at 9:28 a.m., staff member G stated resident #37 previously had a different toilet in her bathroom, which was why there was a large, round, dark brown area around the base of her toilet. Staff member G stated the brown area was, off-putting, and unseemly to look at, and the housekeeping staff should have probably cleaned and waxed the floor to make it look better. A review of the facility's policy, Routine Bathroom Cleaning, revised 9/2022, reflected: Policy: (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to .provide a clean and sanitary environment for residents .to prevent cross contamination . Procedure: .d. Clean inside and outside the sink . .i. Clean entire toilet .

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. 45447 Based on interview and record review, the facility failed to obtain admission physician orders to help maintain or improve a Stage I pressure ulcer for 1 (#98) of 3 sampled residents. Findings include: During an interview on 9/14/22 at 5:04 p.m., staff member B stated the nurse performing a skin assessment upon admission would put in orders for barrier cream, repositioning every two hours, and update the care plan for a newly admitted resident with risk for or a resident with a pressure ulcer. Staff member B stated it would be the assessing nurse's responsibility to get the needed orders from the provider, and the facility had struggled with that due to staffing. Staff member B stated she would want the physician to do a thorough admission assessment of the resident and their skin, and have orders put in place immediately. Review of resident #98's Skin Observationon the day of admission, dated 4/28/22, showed the resident had a Stage I pressure ulcer on his left heel. Review of resident #98's Provider Visit Note, dated 4/29/22, showed the integumentary (skin) system had no problems noted. A review of the facility's document, Admission Checklist, n.d., reflected, Dr. Orders, as an item to be obtained by nursing. Review of resident #98's admission orders reflected a lack of orders for barrier cream, pressure relieving devices, or repositioning. A review of the facility's policy, Pressure Injury Prevention Guidelines, n.d., reflected: Policy: .to promote healing of existing pressure injuries . 3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used . 4. In the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure injury prevention guidelines to provide care, and will notify physician to obtain orders.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 47003 Based on interview and record review, the facility failed to complete a Significant Change assessment within 14 days of admission to hospice care for 1 (#41) of 1 sampled resident. This failure had the potential to cause the resident's needs and goals for end-of-life care to not be met. Findings include: During an interview on 9/12/22 at 4:02 p.m., resident #41 stated he had been admitted to hospice care, a couple months ago. Record review of the facility-contracted hospice company's document, RN admission assessment, dated 7/13/2022, showed resident #41 was admitted to hospice care on 7/13/22, and resident #41 remained in the facility while receiving hospice care. Review of resident #41's facility completed MDS's, showed a Quarterly MDS had been completed on 5/13/2022 and 8/12/2022. There were no Significant Change assessments related to admission to hospice present in the electronic record between 5/13/22 and 8/12/22. Review of facility policy, Assessment Frequency/Timeliness [sic], last revised on 9/22, showed, Within 14 days . a significant change in the resident's phsyical or mental condition a significant change in status assessment will be completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47003 Based on observation, interview, and record review, the facility failed to include both a resident receiving hospice care, and the hospice provider in care planning goals, for 1 (#41) of 1 sampled resident. This failure caused the resident to be frustrated, and to potentially have unmet needs and goals associated with end-of-life care. The facility failed to update a care plan for an ordered therapeutic diet for 1 (#21) of 1 sampled resident. Findings include: A. During an interview on 9/13/22 at 9:43 a.m., resident #41 stated he was frustrated that he did not get to attend a care plan meeting several weeks prior. When he asked the facility staff members why he did not get to attend, they said he was sleeping and did not want to wake him. Resident #41 did not think he was sleeping during the day and time of the meeting, and stated if he was asleep they should have woken him up. During an interview on 9/14/22 at 11:22 a.m., staff member L stated resident #41 had started hospice care a couple months ago, and there was no specific care conference done with the resident's change of status to hospice. The facility usually had done a care conference with a change to hospice care. Staff member L stated they had just completed a recent care plan meeting a few weeks prior to the survey for resident #41, but the resident had refused to attend. During an interview on 9/14/22 at 5:07 p.m., staff member C stated the hospice nurse did not receive an invitation to the care plan conference for resident #41, and the facility developed the patient care plan. Review of the facility policy, Coordination of Hospice Services, last revised 9/2022, showed, The facility and hospice provider will coordinate a plan of care and will implement interventions in accordance with the resident's needs, goals, and recognized standards of practice . During an interview on 9/14/22 at 8:28 a.m., staff member E stated all information regarding hospice care for resident #41 could be found in the hospice binder at the nurse's station. The hospice provider's care plan given to the survey team was faxed from the outside company, it was not present in the facility's hospice binder, located in the nursing station at the time of the survey. 41952 B. During an observation on 9/13/22 at 9:55 a.m., resident #21 was trying to drink thin milk with a straw but was unable to swallow and needed to spit it out. Review of resident #21's diet orders showed he was to have thickened liquids as of 7/28/22. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/14/22 at 4:44 p.m., staff member B stated care plan updates would be done by the MDS coordinator if it coincided with part of an MDS assessment. Staff member B stated if there was another change needed, the morning meeting management team would review and update the care plan. Staff member B stated the managers had their computers with them and logged into the electronic health record during the meetings to see new orders and events. Review of resident #21's Care Plan, last updated 7/18/22, did not show any information related to the thickened liquids ordered on 7/28/22. The Care Plan showed a nutrition deficit and to offer extra fluids in between meals for hydration.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45447 Based on interview and record review, the facility failed to ensure a licensed nurse had the competency to complete a gastrostomy tube medication administration, resulting in a resident not receiving two days' worth of a medication and having decreased consciousness, for 1 (#98) of 1 sampled resident. Findings include: During an interview on 9/14/22 at 11:50 a.m., staff member C stated the unadministered doses of resident #98's Provigil tablet, to be given via gastrostomy tube, on 5/3/22 and 5/4/22, were discovered during the narcotic count on 5/6/22. Staff member C stated she could not remember if the root cause was determined, but thought she remembered staff member F did not administer the medications because the staff member did not know how to, and was scared to. Review of resident #98's narcotic log for Provigil, dated 4/25/22-5/18/22, showed there was no used medication doses from 5/3/22-5/4/22. During an interview on 9/15/22 at 8:35 a.m., staff member E stated she was oriented on how to document medications given in the facility's electronic health record. Staff member E stated if she did not know how to administer a medication by a gastrostomy tube, she would ask someone how to do it. Review of the facility's RN job description, signed by staff member F on 1/13/22, reflected: Essential Functions: .4. Perform various duties to provide quality nursing care to residents to maintain or attain the highest practical level of functioning .as illustrated by the following: .Administer medications and treatments to residents. .Maintain resident clinical files; keep charts updated; document appropriately; . 9. Ability to use the computer to document care, such as eMAR . Review of the facility's document, Nurse Skill Checklist, reflected: Medication Pass: .Understands eMAR and how to use correctly Understands documenting follow up charting . States correct pass procedure (.document administration) .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45447 Based on interview and record review, the facility failed to ensure a resident received the ordered medication for two days, resulting in a significant medication error with the resident having decreased consciousness, for 1 (#98) of 1 sampled resident. Findings include: During an interview on 9/14/22 at 11:50 a.m., staff member C stated the unadministered doses of resident #98's Provigil tablet by staff member F, to be given via gastrostomy tube (G-Tube), on 5/3/22 and 5/4/22, were discovered during the narcotic count on 5/6/22. Staff member C stated she thought staff member F did not give the medication because she was unsure of how to administer the medication, and was scared to. Review of resident #98's MAR, dated 5/2022, reflected an order for, Provigil Tablet 100 MG (Modafinil) Give 100MG via G-tube one time a day for sleep disorder. Review of resident #98's narcotic log for Provigil, dated 4/25/22-5/18/22, showed there was no used medication doses from 5/3/22-5/4/22. Review of resident #98's MAR, dated May 2022, reflected the dose of Provigil was given on 5/3/22 and 5/4/22 by staff member F. This was inconsistent with the narcotic log. Review of resident #98's SBAR Communication Form, dated 5/6/22, reflected the resident had, Decreased consciousness (sleepy, lethargic), due to not getting the ordered Provigil medication doses on 5/3/22 and 5/4/22. Review of the facility's RN job description, signed by staff member F on 1/13/22, reflected: Essential Functions: .4. Perform various duties to provide quality nursing care to residents to maintain or attain the highest practical level of functioning .as illustrated by the following: .Administer medications and treatments to residents. .Maintain resident clinical files; keep charts updated; document appropriately; . 9. Ability to use the computer to document care, such as eMAR .

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F 0805 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41952 Based on interview and record review, the facility failed to provide a therapeutic diet to 1 (#21) of 2 sampled residents, and had incorrectly ordered food preparation cards for 2 (#s 21 and 24) of 2 sampled residents. This failure had the likelihood to cause physical harm from aspiration. Findings include: During an observation and interview, on 9/13/22 at 9:50 a.m., resident #21 was lying in his bed with a bedside table over his lap. He had several regular consistency drinks on the table with straws. Resident #21 had just tried to take a drink of milk and it was dripping down his chin. He grabbed the black waste basket and began to cough and spit the milk back out. Resident #21 stated, I thought I could get the milk down today, but I guess that's not happening. Resident #21 did not know if he had a specialized diet, but it was difficult for him to drink thin liquids and he needed assistance eating. During an interview on 9/14/22 at 9:21 a.m., staff member K stated staff member J put the dietary orders from the dietician, located in a binder in the kitchen office area, into the computer program that the cafeteria staff used to print out each individual resident's food preparation cards. Staff member K stated neither resident #21 nor resident #24 had received nectar thick liquids at breakfast, and staff member J was supposed to have changed their orders in the system. During an interview on 9/14/22 at 2:48 p.m., staff member B stated the facility did not have any training or inservice documented for facility dietary staff related to specialized diets or thickening. During an interview on 9/14/22 at 4:20 p.m., staff member C stated for existing residents, if a new diet was needed, the physician would be notified and an order entered by the nurse, and given to the kitchen to put in their white binder for diet orders. During an interview on 9/15/22 at 8:08 a.m., staff member J stated he entered the orders from the dieticians and nurses into the computer system and the dietary staff used the information to print the food cards to prepare the correct meals for each resident. He was unsure why the dietician's orders in the electronic chart and the binder were incorrect in the food card system. Review of resident food cards used for the breakfast meal on 9/14/22 showed: - resident #21's food card as regular, with no therapeutic alterations listed and, - resident #24's food card was listed to have nectar thick. Review of the facility document, Dietary order listing report, printed 9/13/22 at 12:45 p.m., showed: - [Resident #21] .regular diet, regular texture, nectar thickened liquids consistency. Revision date 8/15/2022. (continued on next page)

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F 0805 Level of Harm - Actual harm Residents Affected - Few	- [Resident #24] .Regular diet, regular/thin consistency. Revision date 4/30/2021. Review of resident #21's Diet Requisition Form, dated 7/28/22, showed, a checkmark by Nectar for thickened liquids with a handwritten note showing, shakes did not need to be additionally thickened. Under the Comments section, *Crush pills* Patient requires 1:1 feeding assist. The form was located in the white kitchen binder and scanned into the electronic health record. Review of resident #24's Diet Requisition Form, dated 4/30/21, located in the white kitchen binder, showed, resident #24 did not have any of the thickened liquids diet alterations marked. Review of the facility policy, Therapeutic Diet Orders, last revised September 2022, showed, .dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form .as prescribed, and, Therapeutic diets are provided only when ordered by the attending physician or a registered or licensed dietician .all diet orders are to be communicated to the dietary department in accordance with facility procedures. The facility did not have a procedure to ensure that all residents were receiving the correctly ordered diets and/or alterations to their diets on the food cards the dietary staff used to prepare meals. 47003

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47003 Based on observation, interview, and record review, the facility failed to remove expired thickening agents from use and storage. This failure had the potential to cause all residents receiving thickened liquids to potentially ingest an expired food item. Findings include: During an observation on [DATE] at 2:38 p.m., the unopened Activia powdered thickener, in the dry goods storage area, was noted to be expired as of [DATE]. During an observation on [DATE] at 8:52 a.m., the liquid thickener in a pump container, located in the kitchen area, was noted to be expired as of [DATE]. During interviews on [DATE] at 8:03 a.m. and 9:21 a.m., staff member K stated all staff were responsible for checking expiration dates on dry goods and foods prior to use. The dry powder located in a container in the cooking area was corn starch, not the powdered thickener from the dry storage, and staff had not used the corn starch for thickening drinks. Staff member K stated they used the liquid thickener from the pump container for residents needing thickened liquids, but they had no residents requiring thickeners at that time. Review of the facility document, Dietary order listing report, printed [DATE] at 12:45 p.m., showed: - [Resident #21] .regular diet, regular texture, nectar thickened liquids consistency. Revision date [DATE].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45447 Based on observation and interview, the facility failed to ensure staff members adhered to proper PPE practices for 1 (#26) of 12 sampled residents, and residents in rooms [ROOM NUMBER]. This had the potential to affect all residents residing in the facility. Findings include: During an observation on 9/13/22 at 9:27 a.m., staff member D walked out of room [ROOM NUMBER] with an N95 mask dangling under her chin and carrying a room tray. Staff member D proceded to go into rooms [ROOM NUMBERS] to pick up room trays and spoke with residents without wearing her mask or performing hand hygiene. During an observation on 9/13/22 at 10:07 a.m., staff member D walked up the 100 hall, holding a food tray, with a procedure mask down below her nose and mouth. During an observation and interview on 9/14/22 at 8:13 a.m., staff member D grabbed a tray from the kitchen, and brought the food tray to resident #26. Staff member D was wearing a procedure mask beneath her nose and mouth. Staff member D stated she knew she was not wearing her mask correctly, and said she did not wear it over her nose and mouth because she could not breathe. During an interview on 9/14/22 at 8:15 a.m., staff member B stated her expectation for staff was to always wear a mask when they were in the facility. According to the CDC, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 2/2/22, HCP, .should wear source control when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors). https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html