| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **275090** | A. BUILDING _____ B. WING _____ | **08/26/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **BEARTOOTH MANOR** | **350 W PIKE AVE COLUMBUS, MT 59019** |

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 0600<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to prevent, identify, protect, assess, and revise interventions for residents from ongoing nonconsensual sexual abuse for 2 (#s12 and 26) of 19 sampled and supplemental residents. Findings include: During an observation and interview on 8/24/20 at 5:45 p.m., resident #26 and resident #12 were observed on the outdoor patio, off the kitchen and dining room, within touching distance of each other, without supervision by staff. Resident #12 stated she was keeping an eye on resident #26. Resident #26 talked about his long stay at facility and his deficits but made no comment regarding resident #12. During an observation on 8/26/20 at 9:13 a.m., residents #12 and #26 were standing together near the nursing station without supervision. During an interview on 8/26/20 at 9:51 a.m., staff member I stated staff were to keep an eye on resident #12 and resident #26 and to keep in common areas only because of inappropriate sexual behavior before. During an interview on 8/26/20 at 10:02 a.m., staff member D stated resident #12 and resident #26 were removed from the situation, staff are to monitor them, and the residents are good about keeping their distance from each other. Staff member D stated she was not even sure who saw them in resident #26's room or how it was found. Staff member D stated #12 had not tried anything inappropriate with other residents. Staff member D stated resident #12 talked to others and did not want to be intimate, but when she does the social worker would do an assessment. During an observation and interview on 8/26/20 at 10:05 a.m., staff members G and H stated they had abuse training about two months ago and go over abuse in general to include dementia, at regular intervals. The staff also have online training. Staff members G and H stated they were not aware of sexual abuse of residents, but that residents #12 and #26 had an inappropriate sexual relationship and staff were to redirect from private rooms but they could be in a common area together. Staff members G and H stated they did not believe that was something care planned and showed their pocket care plans which did not have anything related to the behaviors or incidents between the residents. During an observation on 8/26/20 at 10:19 a.m., resident #12 and resident #26 were observed sitting within touching distance of each other, on the outdoor patio, off the kitchen and dining room area, with no supervision. During an interview on 8/26/20 at 10:23 a.m., staff member A stated the activities director witnessed the incident between resident #12 and #26 on 1/23/20. Staff member A stated a Sexual Consent Assessment was completed for both residents. Staff member A stated resident #12 was found to be unable to consent. Staff member A stated the facility implemented interventions such as an all staff training, to keep residents apart, and to monitor their whereabouts. Staff member A stated the residents could be in common areas, such as the patio, and not directly supervised. Staff member A stated resident #12 at first saw resident #26 as her son and was never inappropriate. Staff member A stated the activities director immediately took resident #12 out of the room, interviewed, and checked resident #12 out. Resident #12 was far enough away from resident #26 to not need a physical exam. Staff member A stated facility management thoroughly investigated the incident by completing assessments, consulting corporate, Adult Protective Services, and giving staff education. Staff member A stated resident #26 was not interested in resident #12. Staff member A stated the facility had consulted resident #12's physician to find out about a medication to curb her libido. Staff member A stated resident #12 was started on a medication called [MEDICATION NAME]. Staff member A stated resident #12 perseverated on resident #26, and resident #12 knows she had to be in a common area with resident #26. Staff member A stated resident #12's room is across from the DON's office, and everyone is observant and aware to keep a close eye on resident #12's behavior. Staff member A stated when abuse occurs staff know to report. During an interview on 8/26/20 at 11:08 a.m., staff member F stated she was the one who witnessed the 1/23/20 event between residents #12 and #26 and entered the room to intervene. Staff member F stated she found resident #26 lying in his bed with resident #12 leaning over him with her shirt pulled up. Staff member F stated she asked the residents to stop the activity, and there was an audible sound of suction released from resident #26's mouth on resident #12's breast when resident #12 turned around. Staff member F stated the residents did not seem in distress and it seemed the residents had been joking around. Staff member F asked the residents to leave the room if they wanted to hang out in a common area, and staff member F brought the residents to the nurse's station. Staff member F then left the nursing station in search of the DON to report the incident and did not know what else happened with the residents on 1/23/20 after they were taken to the nursing station by staff member F. Staff member F notified the Administrator the next morning. Staff member F stated both residents were interviewed on 1/24/20 regarding the event and neither understood why they could not be alone in a room together with the door shut. Staff member F stated resident #12 did not recall the incident. During an interview on 8/26/20 at 2:48 p.m., NF1 stated resident #12 was new to the facility and had no prior knowledge, of resident history prior to admission to the facility. NF1 stated they were notified about the inappropriate sexual behavior about two days before ordering the [MEDICATION NAME] on 1/8/20, to attempt to curb behaviors and lower libido, per a consult with a gerontologist. NF1 has had to increase [MEDICATION NAME] twice since admission for increased behaviors. NF1 was not aware of any assessment or investigation related to incidents or notified at the time of the events to his recollection other than the increased sexual behaviors of resident #12 and being the instigator. During an interview attempt on 8/26/20 at 1:17 p.m. a message was left for NF2. Record review of resident #12's Capacity to Consent assessment signed on 1/24/20 showed resident #12 has a [DIAGNOSES REDACTED]. Under past and present behaviors documentation included, Resident has had sexual ideation toward other residents in the past. Resident has made a comment in the past 'how are we supposed to have sex if the door isn't closed.' Resident was allowing another resident to put his mouth on her breast. Under the Conclusion of Capacity to Consent to Sexual Activity, In the opinion of the IDT team, it is our opinion based on this assessment this resident appears not to be able to consent to sexual activity. Record Review of resident #12's Care Plan review on 6/25/20 showed: - 12/13/19: focus area showed, .I have severe short-term memory deficits and am unable to exercise self-control. I approach others and will pat them on the cheek/back or follows one specific resident around the building. (sic) - 1/24/20: focus area showed, I have been observed to have inappropriate behaviors with male residents. Goal as, I will not go in to other resident rooms, when I want to socialize with other residents it will be common areas. Interventions were documented as, .consult with my provider, who was contacted by a geriatric specialist regarding medication adjustments to help with my libido Staff will intervene as needed when I am observed attempting to enter other residents room and redirect to common areas. (sic) Record review of resident #12's Abuse Prevention Plan, susceptibility to abuse/safety checklist showed: - For the admission, signed 12/8/19, the document showed no for all questions. - The 3/11/20 document showed a yes for, B. Verbally threatening to others, displaying rage or has poor impulse control, or is unable to express anger appropriately G. Exhibiting psychotic behavors such as hallucinations or delusions. (sic) - The 6/12/20 document showed, B. changed to No and A1. explanation of refusal of care as, (Resident #12) does not become abusive to others, she paces the hallways, requires verbal reminders frequently. - Resident #12's Abuse Prevention Plan did not address the risk of potential sexual abuse. Record review of resident #12's |

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

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.

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| F 0600<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>pocket care plan did not show any information under the report info, under the column heading at-risk, was fall risk, in red; and under the column heading Additional Instructions, the document showed dementia. Nothing was noted related to behaviors, inappropriate sexual behaviors, or incidents of abuse. Record review of #12's nursing progress notes, from date of admission on 12/5/19 to 8/26/20, showed documentation of consistent inappropriate sexual behaviors with several male residents, some males noted without capacity to consent: - 12/30/19 - .During distribution of dinner, (sic), CNA noticed female resident (#12) walking toward (resident #26) room. (Resident #26) had become irritated with (resident #12) earlier in the day and had asked her to leave his room. (CNA) asked (resident #12) not to go into (resident #26) room and to 'let him be.' (Resident #12) stated she was 'looking for something down the hall.' (resident #12) proceeded to walk to the end of the hall, waited for (CNA) to leave the hallway, then went into (resident #26's) room and closed the door behind her. (Resident #12) has been asked multiple times by staff not to close the door when she is in (resident #26's) room. This RN immediately went to (resident #26) room and opened the door. (Resident #12) was holding a pair of (residents #26) sweatpants in her hand. RN asked what she was doing and (resident #12) stated 'I am just helping him with his pants.' RN reminded (resident #12) that (resident #26) is independent and does not need help getting dressed. RN requested that (resident #12) leave the room as (resident #26) had previously asked her to leave earlier. (Resident #12) cursed at this RN and stated she was just trying to help him . Later in the evening (resident #12) was observed again going into (resident #26's) room and closing the door behind her. RN responded and reminded both residents that they are welcome to spend time together, but the door needs to remain open . (sic) The note does not show if resident #12 left the room or was checked again. - 1/7/20 - .resident (#12) was observed starting to walk down (hall) to visit a (resident #26). (resident #26) had previously informed staff he was not feeling well and did not want visitors or to be disturbed. (CNA) asked resident (#12) not to bother (resident #26) as he was resting. Resident (#12) ignored CNA and continued down the hall . Resident (#12) states 'I have a right to see him!' ' .You can't stop me.' RN stood in front of door handle to prevent resident (#12) from attempting to open the door to (resident #26) room . Resident (#12) eventually began walking back down the hallway, away from (resident #26's) room, and stated 'Well I will just wait until you aren't looking.' (sic) - 1/8/20 - Resident (#12) behaving inappropriately with multiple residents this evening per CNA report: during supper resident (#12) rubbed her hands on (a male resident) face and head and ignored his requests to stop, became angry with CNA when told to respect (male residents) personal space; While (resident #26) was on the telephone with family resident (#12) interrupted (resident #26) multiple times telling him to end the conversation and 'pay attention to me'. (Resident #26) complained to nursing 'she never leaves me alone' at a later time. (sic) - 1/9/20 - it was reported by (CNA) that resident (#12) was observed by kitchen staff to be sitting on a (male residents') lap during a meal, bouncing and saying, 'come on big boy.' Witnessed resident (#12) touching (second male resident) head and becoming angry ('oh fine then!') when (second male resident) requested resident (#12) stop. (sic) - 1/9/20 - (Physician) called this am and stated he consulted a nursing home specialist in (local hospital) regarding resident (#12) behaviors, he got some advice regarding medications to help, received orders from him to start [MEDICATION NAME] 25 mg po QD and to notify him on Monday how it is working and if we need to we can increase or add some other medications to help with her behaviors. Will monitor behaviors and family notified. (sic) - 1/9/20 - Resident (#12) was found entering the rooms of other residents uninvited. Also entered a male resident's room and closed the door . (sic) - 1/10/20 - .going into male resident's room without being invited and becoming belligerent to staff when told the door must remain open. (sic) - 1/13/20 - Res (#12) was wandering halls this shift, has made multiple attempts to enter other residents' rooms without invitation. (sic) - 1/13/20 - Resident (#12) witnessed opening (resident #26's) door without knocking, peeking in and then closing the door again . (sic) - 1/16/20 - resident has had behaviors x2 this shift for wandering into male patients' room without invitation . (sic) - 1/18/20 - .going into several male resident's rooms without invitation . (sic) - 1/20/20 - .resident (sic) observed to be leading a male resident by pulling on his walker . (sic) - 1/23/20 - On Thursday 1/23/2020 at approximately 4:45 PM, I observed a male resident (#26) lying on his bed and (resident #12) was standing next to his bed, slightly leaning over him. she had her shirt up. after knocking I entered the room. I asked the residents to stop this activity. When she turned around it was apparent that the other resident was touching her breast. I told them both if they wanted to continue to hang out, they needed to do so in a common area. Both residents then exited the room and went to the nurse's station. (sic) - 1/24/20 - resident (#12) has been on increased monitoring by staff for wandering into male patients rooms . (sic) - 1/25/20 - .needed redirection to prevent entering other residents' rooms . (sic) - 1/25/20 - resident (#12) continues to follow male residents around the facility . (sic) - 1/26/20 - CNA reports resident (#12) invited (male resident) into her room and closed the door . - 1/26/20 - resident (#12) has had some behaviors this shift, wandering into male patients room . (sic) - 1/28/20 - Late entry for 01/24/20: Due to sexually inappropriate behaviors that occurred on 01/23/20, residents involved will only interact in common areas. After much discussion of incident with resident (#12), she stated she could not recall the details and denied the incident. Resident does have a DX. of Dementia. (sic) - 1/28/20 - This writer spoke with (resident #12) this AM to discuss her need for affection. .Again she does not recall why I would be talking to her about this subject. We discussed having normal affection toward's others that might be mistaken for a sexual advance. (sic) - 1/30/20 - Resident (#12) in neighboring male residents room . (sic) - 1/31/20 - Resident (#12) went into a male resident's room and closed the door . (sic) - 1/31/20 - Resident (#12) invited male resident into her room . (sic) - 2/4/20 - Prior to resident (#12) retiring to her room for the night around 1900, she attempted to bring two male residents into her room at separate times. One resident was escorted by this RN to his room, the other resident was reminded he is not allowed to be in her room with her . (sic) - 2/5/20 - resident (#12) invited a male resident into her room this evening . (sic) - 2/6/20 - .she (resident #12) invited a male resident into her room . (sic) - 2/10/20 - (Resident #12) continues to go into others rooms .and with (resident #26) spend time together in the common areas and on patio. (sic) - 2/12/20 - resident (#12) has had some behaviors that required redirection, effective by staff, continues to wander with male residents (sic) - 2/14/20 - .resident (#12) pulling a male resident by his walker and became angry with staff when asked to remove her hand, attempting to lead a male resident into her room (sic) - 2/15/20 - .resident (#12) invited male resident her room . (sic) - 2/22/20 - .resident (#12) became angry with staff when asked not to bother male residents while they were eating . (sic) - 2/23/20 - Resident (#12) had some instances of attempting to pull a male resident by his walker .after going into her room for the night resident (#12) was witnessed walking out of a male resident's room with one of his possessions stating 'he gave it to me,' became angry with staff when told this particular resident wasn't cognitively able to give gifts to others . (sic) - 2/23/20 - Resident (#12) seems to be fixated on one male resident. Several times today she had to be redirected . The man is cognitively impaired and doesn't understand . (sic) - 2/24/20 - .resident (#12) attempted to go into a (male resident's) room several times . (sic) - 2/25/20 - Resident (#12) was attempting to follow a male resident to his room . male resident was recently moved to a different room as (resident #12) was frequently disturbing the male resident when he was in his room . (sic) - 3/2/20 - spoke with (resident #12) regarding her behavior towards male peers, sexual advances. She again denies having sexual desires . (sic) - 3/4/20 - .she (resident #12) was following a few of the men through the facility and shouted out to one of them as he passed by her that he forgot to give her a kiss . (sic) - 3/13/20 - .Resident (#12) also invited a male resident into her room to fix her tv, became hostile when told this wasn't allowed, male resident stated understanding and left without incident. (sic) - 4/18/20 - resident (#12) has had a few episodes of behaviors this shift, attempting to wander into isolation rooms, staff required to redirect, effective. had had 1 episode of wandering with male resident, redirection effective. (sic) - 4/23/20 - Mild negative behaviors this shift resident (#12) required redirection when attempting to enter a male resident's room today . (sic) - 5/2/20 - Resident (#12) continues to pursue a male resident every time she accidentally runs into him in the hallway. He tries to leave the scene and go to his room or outside but she pursues him and makes very angry statements like 'What's wrong with you . how come you runaway every time I get near you .' etc. At this time, because this nurse asked her to stand six feet apart from this particular male, and because she was asked to please stay inside, she's standing in front of the nursing station yelling she should be allowed to go outside with this man if she wants to . (sic) - 6/27/20 - .nurse asked her (resident #12) to please come back when she started walking down (male residents hall) with another resident. At that time, she turned around and yelled at him 'I know!!' . and began to try and argue loudly with him . (sic) - 7/19/20 - .she (resident #12) began to stalk one of the male residents. She continued to go down the hall his room is located on and approach the door. she required redirection numerous times as she approached his door as she would wait until no one was watching her and sneak down the hallway to his room, so staff continued to find her at his doorway numerous times . Later in the shift, her target changed . (sic) - 7/24/20 - .around 1600 she (resident #12) began to walk down the hallway to the residents room who she stalks . (sic) - 7/30/20 - This resident (#12) was yelling at staff today for not allowing her to go to a male residents room with him . |

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| F 0600<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>(sic) - 7/31/20 - res (#12) noted to have a purple bruise on R inner knee when she was sitting in chair at med cart. res denies any pain, but she is unable to tell me what happened. will continue to assess. (sic) - 8/20/20 - res (#12) was very confrontational this shift with this nurse while I was trying to give meds to another res. (Resident #12) was not going to let him sit down 'on her chair' to take his pills. she said he didn't need to sit there and he should just go to his room. she almost pulled the walker out from under him had I not grabbed it. she said he didn't need to be out here and I need to stay out of her business. I said no I was helping him and that she needs to not pick on him. she said she was in charge as she was pointing her finger at me while I tried to keep her from getting near other res. res so called husband, son, etc. was the one who talked her into going outside with him while he smoked. (sic) - 8/20/20 - IDT team met to discuss recent events, (resident #26) states that they joke around all the time and that they are friends and he thought nothing of the incident. (Resident #12) has such severe dementia, she doesn't even recall the incident, provider for (resident #12) has been notified and he did increase her medication in the past week and we will continue to evaluate effectiveness as it can take some time for optimal effect. (sic) - 8/21/20 - resident became verbally aggressive with staff this evening when told she could not accompany a male resident to his room, not able to redirect. (sic) Record Review of resident #26's Capacity to Consent assessment signed 1/24/20 showed, resident #26 had a BIMS score of 15; no cognitive issues, [DIAGNOSES REDACTED].[MEDICAL CONDITION] without behavioral disturbance, .major [MEDICAL CONDITION] altered mental status . Under past and present behaviors/actions, Resident was observed by staff with his mouth on another residents breast. Under the conclusion of Capacity to Consent to Sexual Activity, the document showed, In the opinion of the IDT team, it is our opinion based on this assessment this resident appears not to be able to consent to sexual activity. Record Review of resident #26's care plan last updated on 7/30/30 showed under the heading Focus, entered on 1/24/20, I have been observed by staff having a vulnerable female resident in my room. Record review of resident #26's Abuse Prevention Plan, susceptibility to abuse/safety checklist showed: - 1/15/20, showed, yes for A. Assaultive, combative, or abusive to others or refuses care; B. Verbally threatening to others, displaying rage or has poor impulse control, or is unable to express anger appropriately; G. exhibiting psychotic behavors (sic) such as hallucinations or delusions; is a smoker; and entered under A1 the document showed, (Resident #26) gets irritated easily and becomes verbally abusive. - 4/16/20, showed yes for the same as 1/15/20 with the addition of, H. confused and is repetitive or perseverates with loud vocalizations and entered under A1 the document showed, (Resident #26) becomes verbally abusive towards staff when he becomes agitated. - 7/17/20, changed G and H from yes to a no and entered under A1 the document showed, (Resident #26) become verbally abusive towards staff at times as he is straight forward with his comments. - Resident #26's Abuse Prevention Plan does not address the risk for potential sexual abuse. Record review of resident #26's nursing progress notes from December 2019 to 8/26/20 showed: - 12/30/19 - .During distribution of dinner, (CAN) noticed female resident (#12) walking toward (resident #26) room. (Resident #26) had become irritated with (resident #12) earlier in the day and had asked her to leave his room. (CNA) asked (resident #12) not to go into (resident #26) room and to 'let him be.' (resident #12) stated she was 'looking for something down the hall.' (resident #12) proceeded to walk to the end of the hall, waited for (CNA) to leave the hallway, then went into (resident #26's) room and closed the door behind her. (Resident #12) has been asked multiple times by staff not to close the door when she is in (resident #26's) room. This RN immediately went to (resident #26) room and opened the door. (Resident #12) was holding a pair of (residents #26) sweatpants in her hand. RN asked what she was doing and (resident #12) stated 'I am just helping him with his pants.' RN reminded (resident #12) that (resident #26) is independent and does not need help getting dressed. RN requested that (resident #12) leave the room as (resident #26) had previously asked her to leave earlier. (Resident #12) cursed at this RN and stated she was just trying to help him . Later in the evening (resident #12) was observed again going into (resident #26's) room and closing the door behind her. RN responded and reminded both residents that they are welcome to spend time together, but the door needs to remain open . (sic) The note does not show if (resident #12) left the room or was checked again. - 1/23/20 - Late Entry: Note text: On Thursday 1/23/20 at approximately 4:45 PM, I observed (resident #26) lying on his bed and a female resident (#12) was standing next to his bed, slightly leaning over him. She had her shirt up. After knocking, I entered the room. I asked the residents to stop this activity. When she turned around it was apparent that he had her breast in his mouth. I told them both if they wanted to continue to hang out, they needed to do so in a common area. Both residents then exited the room and went to the nurse's station. (sic) - 1/28/20- .Late entry for 01/24/20: Due to sexually inappropriate behaviors that occurred on (1/23/20), residents involved will only interact in common areas. After much discussion of incident with resident, he stated he could not recall the details and denied the incident. Resident does have a DX. of Dementia. (sic) Record review of facility policy Abuse Prevention Plan-Montana Policy showed: .it is our policy that all residents residing in the facility will be protected from abuse, neglect . and that interventions are implemented to provide the vulnerable adult with a safe living environment. Under the heading Sexual Abuse, .Generally, sexual contact is nonconsensual if the resident either: i. Appears to want the contact to occur but lacks the cognitive ability to consent, ii. or does not want the contact to occur. Under heading Injuries of Unknown Source, a. The source of injury was not observed by any person or the source of the injury could not be explained by the resident . Under the heading Sexual assault, f. Any sexual activity that occurs when an individual cannot or does not consent Under the heading Prevention, g. The assessment, care planning and monitoring of residents with needs .and behaviors which might lead to conflict or neglect (such as: Verbal, physical or sexual aggression, wandering) . Under the heading Investigation, d. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause .6. Facility will complete incident reports by licensed staff immediately following the incident. Under the heading Protection, 1. Residents, the alleged perpetrator, other staff and the integrity of the investigation will be protected from harm during the investigation. a. The accused abuser must be separated from all dependent adults . b. Examine alleged victim for any sign of injury, including a physical exam or psychosocial assessment, if needed . f. Facility will take appropriate corrective action as a result of the investigation findings and ensure this action is effective. Under the heading Reporting and Response, 1. The facility requires that all suspected maltreatment will be reported to the Administrator and the State Promptly . a. All alleged violations involving abuse, neglect .are reported immediately but not later than 2 hours after allegation is made, if the events that cause the allegation involve abuse . 7. Any reasonable suspicion of a crime against a resident .will be reported immediately but no later than 2 hours to the Administrator, State Survey Agency (SA) and one or more law enforcement entities .not later than 24 hours if the events that cause suspicion of a crime do not result in serious bodily injury. Under the heading Internal Reporting, 1. All incidents that are suspicious in nature will be investigated by the internal process. 2. Upon receipt of the report, the DNS or designee on duty will begin investigation the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document findings. 5. Facility will accomplish this by completing the Accident/Incident report or issue and concern form. Record review of the document Signs and Symptoms of Abuse and Neglect, attached to the Abuse Policy, under the heading Investigation, 2. All incidents will be tracked to determine if there is a pattern or trend. 3. All incidents will have an intervention at the time of the incident and care planned to attempt to reduce the chances of a repeat incident. |
| F 0610<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to have evidence of a thorough investigation, failed to notify law enforcement of alleged sexual abuse, and failed to take appropriate corrective action as a result of the investigation for 2 (#s 12 and 26) of 19 sampled and supplemental residents. Findings include: During an observation and interview on 8/24/20 at 5:45 p.m., resident #26 and resident #12 were observed on the outdoor patio, off the kitchen and dining room area, within touching distance of each other, without supervision by staff. Resident #12 stated she was keeping an eye on resident #26. Resident #26 talked about his long stay at facility and his deficits but made no comment regarding resident #12. During an interview on 8/26/20 at 9:51 a.m., staff member C stated resident #12 thought of resident #26 as her person since her admission. Staff member C stated she was not aware of a sexual encounter between resident #12 and resident #26 until the following day but did talk with both residents. Staff member C stated management had implemented resident #12 to not be able to go into resident #26's room and when residents were together it needed to be in an open area. Staff member C stated resident #12 did not recall the event and did not think it happened. Resident #26 said he did not remember it, however staff member C stated she did believe he was aware of it. Staff member C stated when management spoke to resident #12's family, they just said since she has this dementia, she often does bizarre things. Staff member C stated resident #12 often went outside on the patio with other male residents. Staff member C stated facility staff keep track of resident #12's whereabouts and does not approach others like resident #26. Staff member C stated she did not |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275090 | A. BUILDING _____ B. WING _____ | 08/26/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BEARTOOTH MANOR | 350 W PIKE AVE COLUMBUS, MT 59019 |

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 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 3)<br>recall doing other sexual consent capacity assessments for other residents. Staff member C stated facility staff only asked if other residents felt safe here. Staff member C stated something like this would not reoccur. Staff member C stated staff member A had spoken to the family about the incident. During an interview on 8/26/20 at 10:23 a.m., staff member A stated the activities director witnessed the incident between resident #12 and #26 on 1/23/20. Staff member A stated a Sexual Consent Assessment was completed for both residents. Staff member A stated resident #12 was found to be unable to consent. Staff member A stated the facility implemented interventions such as an all staff training, to keep residents apart, and to monitor their whereabouts. Staff member A stated the residents could be in common areas, such as the patio, and not directly supervised. Staff member A stated resident #12 at first saw resident #26 as her son and was never inappropriate. Staff member A stated the activities director immediately took resident #12 out of the room, interviewed, and checked resident #12 out. Resident #12 was far enough away from resident #26 to not need a physical exam. Staff member A stated facility management thoroughly investigated the incident by completing assessments, consulting corporate, Adult Protective Services, and giving staff education. Staff member A stated resident #26 was not interested in resident #12. Staff member A stated the facility had consulted resident #12's physician to find out about a medication to curb her libido. Staff member A stated resident #12 was started on a medication called [MEDICATION NAME]. Staff member A stated resident #12 perseverated on resident #26, and resident #12 knows she had to be in a common area with resident #26. Staff member A stated resident #12's room is across from the DON's office, and everyone is observant and aware to keep a close eye on resident #12's behavior. Staff member A stated when abuse occurs staff know to report. During an interview on 8/26/20 at 11:08 a.m., staff member F stated she was the one who witnessed the 1/23/20 event between residents #12 and #26 and entered the room to intervene. Staff member F stated she found resident #26 lying in his bed with resident #12 leaning over him with her shirt pulled up. Staff member F stated she asked the residents to stop the activity, and there was an audible sound of suction released from resident #26's mouth on resident #12's breast when resident #12 turned around. Staff member F stated the residents did not seem in distress and it seemed the residents had been joking around. Staff member F asked the residents to leave the room if they wanted to hang out in a common area, and staff member F brought the residents to the nurse's station. Staff member F then left the nursing station in search of the DON to report the incident and did not know what else happened with the residents on 1/23/20 after they were taken to the nursing station by staff member F. Staff member F notified the Administrator the next morning. Staff member F stated both residents were interviewed on 1/24/20 regarding the event and neither understood why they could not be alone in a room together with the door shut. Staff member F stated resident #12 did not recall the incident. During an interview on 8/26/20 at 2:27 p.m. staff member A stated, the copied Post-It note was hers from when the family called regarding another matter, and staff member A informed the family of the 1/23/20 incident, which was found in their investigation file, but forgot to enter into the resident chart. Staff member A stated resident #26 does not have family and is his own person. Staff member A stated staff member B forgot to do a risk management report for the incident, and the daily quality conference print out shows for #12 a skin assessment was noted as done however, there was no documentation of one occurring in the resident chart or anyone who could explain findings of a skin assessment being completed. Record review of 1/23/20 if the facility self-reported event showed, incident was witnessed by a staff member so there was no further investigation. Record review of the 1/23/20 incident investigation documents showed: - A copy of a handwritten Post-it note with no name, signature, or date noting family was informed of an incident on 1/23/20. No documentation was in either residents' chart. - A print off from the facility Quality Conference Action Items form for 1/24/20 was not the original and not signed by staff present; the document showed resident #12's actions as complete skin assessment done and notify Dr. about incident done. No documentation of a skin assessment or notification of physician was documented in the residents' charts. - The facility incident report Risk Management Report was not completed. - Law Enforcement was not contacted. - There was not a full investigation conducted for this incident, and it was not prevented from happening with prior knowledge of escalated behaviors. Record review of facility policy Abuse Prevention Plan-Montana Policy showed: .it is our policy that all residents residing in the facility will be protected from abuse, neglect . and that interventions are implemented to provide the vulnerable adult with a safe living environment. Under the heading Sexual Abuse, .Generally, sexual contact is nonconsensual if the resident either: i. Appears to want the contact to occur but lacks the cognitive ability to consent, ii. or does not want the contact to occur. Under heading Injuries of Unknown Source, a. The source of injury was not observed by any person or the source of the injury could not be explained by the resident . Under the heading Sexual assault, f. Any sexual activity that occurs when an individual cannot or does not consent Under the heading Prevention, g. The assessment, care planning and monitoring of residents with needs .and behaviors which might lead to conflict or neglect (such as: Verbal, physical or sexual aggression, wandering) . Under the heading Investigation, d. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause .6. Facility will complete incident reports by licensed staff immediately following the incident. Under the heading Protection, 1. Residents, the alleged perpetrator, other staff and the integrity of the investigation will be protected from harm during the investigation. a. The accused abuser must be separated from all dependent adults . b. Examine alleged victim for any sign of injury, including a physical exam or psychosocial assessment, if needed f. Facility will take appropriate corrective action as a result of the investigation findings and ensure this action is effective. Under the heading Reporting and Response, 1. The facility requires that all suspected maltreatment will be reported to the Administrator and the State Promptly a. All alleged violations involving abuse, neglect .are reported immediately but not later than 2 hours after allegation is made, if the events that cause the allegation involve abuse 7. Any reasonable suspicion of a crime against a resident will be reported immediately but no later than 2 hours to the Administrator, State Survey Agency (SA) and one or more law enforcement entities .not later than 24 hours if the events that cause suspicion of a crime do not result in serious bodily injury. Under the heading Internal Reporting, 1. All incidents that are suspicious in nature will be investigated by the internal process. 2. Upon receipt of the report, the DNS or designee on duty will begin investigation the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document findings. 5. Facility will accomplish this by completing the Accident/Incident report or issue and concern form. Record review of the document Signs and Symptoms of Abuse and Neglect, attached to the Abuse Policy, under the heading Investigation, 2. All incidents will be tracked to determine if there is a pattern or trend. 3. All incidents will have an intervention at the time of the incident and care planned to attempt to reduce the chances of a repeat incident. |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure 5 ml Luer lock syringes were disposed of after their expiration date of ,[DATE]. This has the potential to affect any resident receiving medication from the syringes. Findings include: During an observation and interview on [DATE] at 9:00 a.m., of the medication storage room, there were twenty-six, 5 milliliter Luer lock disposable syringes without needles, with an expiration date of ,[DATE]. Staff member D stated she checks the expiration dates (for supplies), in the medication storage room, every three months. During an interview on [DATE] at 11:09 a.m., staff member B stated the medication storage room was checked monthly for expiration dates of medications and biological's. Staff member B stated there was one nurse on nightshift who probably goes through it more often than monthly. Review of the facility's policy, dated ,[DATE], showed, the Facility should ensure that medication and biological's: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or, (3) have been contaminated or deteriorated, are stored separately from their medications until destroyed or returned to the pharmacy or supplier. |
| F 0806<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.**<br><br>Based on observation, interview, and record review, the facility failed to ensure 2 (#s 18 and 20) of 15 sampled residents |

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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 0806<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 4)<br>were provided the choice of food prior to the meal service and failed to provide food of the residents' preference at the time of meal. Findings include: During an observation and interview on 8/24/20 at 4:49 p.m., resident #18 stated the residents were not given a menu, informed by staff of what the meal was, or any choice for meals. Resident #18 stated the residents are given trays and just eat what they can tolerate. During an observation and interview on 8/24/20 at 6:05 p.m., staff member J stated the facility had set meals daily, and then there was an alternative for the residents if they wanted something different. Staff member J stated the nursing staff on the floor let the residents know what the meals were and if they want an alternative they let the kitchen know before the meal. During an observation on 8/24/20 at 6:22 p.m., resident #18's dinner tray was being delivered by staff member C, which was a turkey salad sandwich, tomato soup, watermelon, and drinks. Resident #18 told staff member C she did not like the turkey salad sandwich, but she preferred whole meat sandwiches. Staff member C went back to the kitchen to request an alternative and returned later with a tuna salad sandwich. Resident #18 was even more adamant she would not eat it as she is allergic to shellfish and dislikes tuna fish and salad sandwiches. Staff member C stated she would return to the kitchen to request a different sandwich. During an interview on 8/25/20 at 9:34 a.m., resident #20 stated the residents did not get a food choice for any meals. During an observation and interview on 8/26/20 at 9:49 a.m., staff member J stated the 8/24/20 dinner entre was switched with the day before, because some food items were not found by the cook on duty, to prepare the 8/23/20 dinner, and staff J showed documentation of the approved substitution form by the dietician. During an interview on 8/26/20 at 10:11 a.m., staff members G and H stated the activities department went around to the residents to ask what choice they wanted for meals. Staff members G and H stated the menu was posted in the dining room and they only knew of one resident who had a menu in their room. During an interview on 8/26/20 at 11:04 a.m., staff member F stated activities had been going around asking residents what choice they wanted for meals months before, but they were no longer doing it with the several dietary manager changes, and the meal process had changed. Record review of resident #18's meal card for 8/24/20 dinner showed resident #18 was to receive: a grilled ham and cheese sandwich, potato wedges and ketchup, marinated green bean salad, seedless watermelon, and cream of potato soup with saltine crackers, 2% milk, coffee or hot tea. Record review of resident #18 care plan printed 8/25/20 showed resident #18 is known to have an intolerance, allergy, or preference of disliking shellfish and tuna fish, specifically. |