STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275026	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IVY AT GREAT FALLS	**1130 17TH AVE 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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide 9 (#s 1, 4, 8, 9, 10, 11, 12, 13, and 14) of 22 sampled and supplemental residents with a Transfer or Discharge Notice prior to the residents leaving the facility. Findings include: 1. During an interview on 8/12/2020 at 4:07 p.m., resident #1 said the facility did not have him sign, nor did they provide him with a Transfer or Discharge Notice, before he was transported to the hospital on [DATE] During an interview on 8/13/2020 at 7:40 a.m., staff member A said he would check to see if a Transfer or Discharge Notice was given to resident #1 prior to the resident being transported to the hospital on [DATE]. During an interview on 8/13/2020 at 8:56 a.m., staff member A said he had not found a Transfer or Discharge Notice for resident #1's most recent transport to the hospital on [DATE]. Staff member A said, Unfortunately this happens sometimes and the nurse just doesn't get it done. 2. During an interview on 8/12/2020 at 10:16 a.m., staff member F said the unit nurse was supposed to complete the Transfer or Discharge Notice for a resident prior to the resident being transferred to the hospital or another facility. Staff member F said each unit had discharge packets and the nurse was supposed to pull and complete it prior to a resident leaving the facility for transfer to a hospital or another facility. Staff member F said the resident, if able, should sign the Transfer or Discharge Notice. The staff member said if the resident was unable to sign the document, the resident's representative or power of attorney should sign it as soon as possible. Review of the facility's discharged residents, from 4/1/2020 to 8/11/2020, showed eight residents, #s 4, 8, 9, 10, 11, 12, 13, and 14, had not received a Transfer or Discharge Notice as required by the facility's policy. Review of the facility's policy, Transfer or Discharge Notice, showed: 2. Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge: f. An immediate transfer or discharge is required by the resident's urgent medical needs;
F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform 1 (#1) of 7 sampled residents, in writing, of the facility's Bed Hold Notice prior to the resident transferring to the hospital. Findings include: Resident #1 was transferred, by ambulance, to the hospital on [DATE] for emergent care. During an interview with resident #1 on 8/12/2020 at 4:07 p.m., he said the facility did not give him a Bed Hold notice before he was transferred to the hospital. Resident #1 said he had been in the hospital for over a month and still had not received a notice from the facility. During an interview on 8/13/2020 at 7:40 a.m., staff member A said he thought the nurse failed to give resident #1 a Bed Hold Notice prior to his transfer to the hospital. Staff member A said he would look again to see if he could find a Bed Hold Notice for resident #1. During an interview on 8/12/2020 at 10:16 a.m., staff member F said the unit nurse was supposed to give the Bed Hold Notice to the resident prior to the resident being transferred to the hospital or another facility. Staff member F said each unit had discharge packets the nurse was supposed to pull and complete prior to a resident leaving the facility for transfer to a hospital or another facility, and the Bed Hold Notice was in that packet. During an interview on 8/13/2020 at 8:56 a.m., staff member A said he did not find a Bed Hold Notice for resident #1 when he transferred to the hospital on [DATE]. Review of the facility's policy Transfer or Discharge Notice included the following: 3. The resident and/or representative (sponsor) will be notified in writing of the following information: . e. The facility bed-hold policy;

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.