| 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 _____ | 07/30/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| PARK PLACE TRANSITIONAL CARE AND REHABILITATION | 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.

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| F 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br><br>Based on interview and record review, the facility failed to prevent alleged abuse for 4 (#s 18, 19, 20, and 22) of 22 sampled and supplemental residents. Findings include: During an interview on 7/28/20 at 9:43 a.m., staff member S stated resident #19 alerted her that NF4 had been rough with resident #22 during cares. Staff member S explained NF4 was suspended immediately; he did not respond to the facility's phone calls and did not return to work. Staff member S stated, I founded that (particular) abuse allegation based on resident statements. During an interview on 7/28/20 at 1:02 p.m., staff member A stated the facility was unable to interview NF4 following the abuse allegation. Staff member A explained that because staff were unable to get a statement from NF4, the abuse allegation was substantiated. Review of resident #18's statement, dated 2/9/20, showed: (NF4) is very rough with me. I told him he was hurting my leg and he ignored me, and (NF4) kept doing what he was doing. Review of resident #19's statement, dated 2/9/20, showed: Approximately 3 weeks ago, I walked by (resident #22) in (her room). She was make (sic) noises like she was hurt. I stood there in the doorway and watched NF4 jerk the pillow out from under her broken leg. Then (NF4) jerked the pillow out from under her casted arm. He then turned around, saw me and said he needed privacy for a 'Depends change,' and shut the door. (Resident #22) started shaking and was very agitated. Review of resident #20's statement, dated 2/9/20, showed: (NF4) came in to help me go to the bathroom; I wasn't moving fast enough so he grabbed my pants and jerked them down really fast, and kind of rough. Review of NF4's personnel file showed a background check was completed upon hire, and his CNA license was active until 11/30/21. NF4 had received education on abuse from the facility 11/15/19. Review of the facility's Abuse and Neglect In-Service, dated 2/7/20, showed: Behaviors that are physically abusive include: .rough handling. The same document showed: Verbal, sexual, physical, and mental abuse are strictly prohibited. |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Respond appropriately to all alleged violations.**<br><br>Based on interview and record review, the facility failed to provide evidence that showed a thorough investigation was completed following abuse allegations against one employee for 4 (#s 18, 19, 20, and 22) of 22 sampled and supplemental residents. Findings include: During an interview on 7/28/20 at 9:43 a.m., staff member S stated that following the abuse allegation against NF4, residents were interviewed, but a full investigation did not occur as NF4 terminated himself by not returning to work. Staff member S explained that if the facility had been able to interview NF4, she would have interviewed other staff members as part of the investigation. Additionally, staff member S stated there was no reason to continue monitoring the residents who gave statements or other residents potentially at risk of abuse because NF4 did not return to the facility. Staff member S explained the facility protected the residents by terminating NF4 and described the specific incident as isolated to that staff member. During an interview on 7/28/20 at 1:02 p.m., staff member A stated, We couldn't get to the bottom of (the allegation involving NF4) without his statement, so there wasn't any more of an investigation. Review of the facility's Abuse Investigation and Reporting policy, dated 10/20/16, showed the following: -The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation .The Administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented. -The individual conducting the investigation will, as a minimum: interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors; interview other residents to whom the accused employee provides care or services; and review all events leading up to the alleged incident. Review of the facility's documentation surrounding the incident with NF4 showed resident interviews were completed; however, no interviews with staff, family members, or other residents, who may have been affected, were completed. Refer to F0600 |
| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to revise and implement the care plan for oxygen for 3 (#s 2, 3, and 5) of 5 sampled residents. This failure had the potential to affect any resident in the facility who required oxygen. 1. During an observation and interview on 7/28/20 at 8:00 a.m., resident #2 was sitting in her room eating breakfast. Resident #2 had her oxygen nasal cannula on and the concentrator was set to 4L. Resident #2 stated she had no problems with her oxygen. She stated the staff put the oxygen on for her. Review of resident #2's care plan with a revision date 6/20/19, showed, . I wear oxygen per nasal cannula at 2-3 liters continuously, . Review of resident #5's Order Summary Report for July 2020 did not show a physician's orders [REDACTED]. 2. During an observation on 7/27/20 at 1:45 p.m., resident #3 was in her room, sitting in her wheelchair. Her oxygen cannula was in her nose and the oxygen rate on the tank was set at 3L. The oxygen tank was in the red, which meant it required replacement. During an observation on 7/27/20 at 3:25 p.m., resident #3 was sitting in the television room by the nursing station. Resident #3 had her oxygen on, the tank remained in the red, showing it needed to be replaced. During an observation on 7/28/20 at 12:20 p.m., resident #3 was in her room sitting in her wheelchair. Her oxygen nasal cannula was in her nose, the oxygen rate on the tank was set at 4L. The oxygen tank was in the red, showing it needed to be replaced. During an observation on 7/28/20 at 1:55 p.m., resident #3 was in her room sitting in her wheelchair. Her oxygen nasal cannula was in her nose, the oxygen rate on the tank was set at 4L. The oxygen tank was in the red, showing it needed to be replaced. During an observation on 7/29/20 at 8:00 a.m., resident #3 was lying in bed, waiting for her breakfast. Resident #3 had her oxygen nasal cannula on her face, hooked to the oxygen concentrator, which was set at 2L. During an interview on 7/28/20 at 2:00 p.m., staff member L stated resident #3 should have her oxygen set at 4L. During an interview on 7/29/20 at 8:05 a.m., staff member CC stated resident #3 should have her oxygen set at 4L. Review of resident #3's Order Summary Report and the Medication Review Report, dated 7/7/20, showed resident #3's oxygen was continuous to keep oxygen saturations at or above 88%. Based on interviews, the facility staff were not aware of resident #3's current oxygen orders. Review of resident #3's care plan showed the oxygen interventions were last updated on 3/28/20 for the use of oxygen. The care plan did not specify the amount of oxygen to use, or when the resident was to use the oxygen. 3. During an observation on 7/28/20 at 12:00 p.m., resident #5 was in her room, sitting in her wheelchair, eating candy, and reading. Resident #5 had an oxygen nasal cannula on, hooked up to an oxygen concentrator, which was set at 2L. During an interview on 7/28/20 at 8:05 a.m., staff members CC and DD stated the staff could look at the Kardex for information on how to assist residents with their care, or they could ask another staff |

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

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| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>member. Review of resident #5's Order Summary Report for July 2020 did not show a physician's orders [REDACTED].#5's care plan, dated 12/2/18, showed oxygen at 2L per nasal cannula at bedtime. Review of resident #5's Kardex showed, oxygen settings at 2L via nasal cannula at bedtime. |
| F 0658<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to follow physician orders for oxygen for 2 (#s 2 and 3); and failed to obtain a physician order for [REDACTED]. Findings include: 1. During an observation and interview on 7/28/20 at 8:00 a.m., resident #2 was sitting in her room, eating breakfast. Resident #2 had her oxygen nasal cannula on, and the concentrator was set to 4L. Resident #2 stated she had no problems with her oxygen. She stated the staff put the oxygen on for her. Review of resident #2's Order Summary Report, dated 7/28/20, did not show an order for [REDACTED]. During an observation on 7/27/20 at 1:45 p.m., resident #3 was in her room, sitting in her wheelchair. Her oxygen cannula was in her nose, and the oxygen rate on the tank was set at 3L. The oxygen tank was in the red, which meant it needed to be replaced. During an observation on 7/27/20 at 3:25 p.m., resident #3 was sitting in the television room by the nursing station. Resident #3 had her oxygen on, the tank remained in the red, showing it needed to be replaced. Staff member K obtained her oxygen saturation at 90%. Staff member K stated the oxygen saturation was checked every shift. Staff member K then asked another staff member to replace resident #3's oxygen tank. Staff member K provided the surveyor a form titled, Oxygen & Equipment Order, dated 3/26/20. The form showed resident #3 was to have oxygen at 4 LPM continuous via nasal cannula. During an observation on 7/28/20 at 12:20 p.m., resident #3 was in her room, sitting in her wheelchair. Her oxygen nasal cannula was in her nose, the oxygen rate on the tank was set at 4L. The oxygen tank was in the red, showing it needed to be replaced. During an observation on 7/28/20 at 1:55 p.m., resident #3 was in her room, sitting in her wheelchair. Her oxygen nasal cannula was in her nose, the oxygen rate on the tank was set at 4L. The oxygen tank was in the red, showing it needed to be replaced. During an observation on 7/29/20 at 8:00 a.m., resident #3 was lying in bed, waiting for her breakfast. Resident #3 had her oxygen nasal cannula on her face, hooked to the oxygen concentrator which was set at 2L. During an interview on 7/28/20 at 2:00 p.m., staff member L stated resident #3 should have her oxygen set at 4l. Staff member L obtained a new oxygen tank to replace resident #3's empty tank. Staff member L checked resident #3's oxygen saturation, which was 90%. During an interview on 7/29/20 at 8:00 a.m., staff members CC and DD stated most of the residents have their oxygen orders between 2 and 4 liters. During an interview on 7/29/20 at 8:05 a.m., staff member CC stated resident #3 should have her oxygen set at 4L. Review of resident #3's Order Summary Report and the Medication Review Report, dated 7/7/20, showed resident #3's oxygen was continuous to keep oxygen saturations at or above 88%. Based on interviews, the facility staff were not aware of resident #3's current oxygen orders. 3. During an observation on 7/28/20 at 12:00 p.m., resident #5 was in her room, sitting in her wheelchair, eating candy and reading. Resident #5 had an oxygen nasal cannula on, hooked up to an oxygen concentrator, which was set at 2L. During an interview on 7/28/20 at 8:05 a.m., staff members CC and DD stated the staff could look at the Kardex for information on how to assist residents with their care, or they could ask another staff member. Review of resident #5's Order Summary Report for July 2020 did not show a physician's order for oxygen. Review of the facility policy titled, Oxygen Administration, showed, . 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. 2. Review the resident's care plan and assess for any special needs of the resident . |
| F 0676<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.**<br><br>Based on observation, interview, and record review, the facility failed to provide the proper level of assistance; and failed to proivde an assistive device for meals for 1 (#10) of 21 sampled and supplemental residents, which had the potential to affect all residents who required assistance with meals and assisitve devices. Findings include: During an observation on 7/29/20 at 8:05 a.m., resident #10 was eating in her room, lying in bed, in the dark, with her bedside table over her bed, and her breakfast tray on top of it. There was no red foam on her silverware handles. During an observation on 7/29/20 at 8:07 a.m., staff member W entered resident #10's dark room and offered her a bite of cereal. Staff member W did not turn on the light in resident #10's room. The silverware did not have red foam on the handles for resident #10. During an observation on 7/29/20 at 8:09 a.m., staff member R entered resident #10's dark room and opened the shades. During an observation on 7/29/20 at 1:18 p.m., resident #10's plate had silverware with red foam on the ends of both her fork and spoon. She had consumed less than 25% of her meal. During an interview on 7/28/20 at 12:45 p.m., staff member Y stated there was a communication form for resident #10 that addressed her level of assistance for meals. During an interview on 7/28/20 at 2:14 p.m., staff member V stated resident #10 often does not have the endurance to eat with her dominant hand and resorts to using her utensil in her non-dominant hand to eat some of her meal. Staff member V stated resident #10 needed more supervision and assistance during her meals. During an interview on 7/29/20 at 8:12 a.m., staff member R stated, I don't think (resident #10's) silverware has any foam on them. She walked into resident #10's room and confirmed there was no foam on the silverware. During an interview on 7/29/20 at 8:54 a.m., staff member B stated staff was to encourage resident #10 to eat during her meals. Staff member B stated resident #10 did not use foam on her silverware as an assistive device during meals. During an interview on 7/29/20 at 10:29 a.m., staff member W stated she did not know if resident #10 was supposed to use an assistive device on her silverware. Staff member W stated she would look at her book, on a computer, or ask the nurse or dietician to find out whether a resident needed an assistive device for meal such as foam on the silverware. Review of the facility's Communication Form for resident #10, dated 7/24/20, showed, Please provide assistance at meals due to self-feeding difficulty and weight loss. The form had boxes checked for breakfast, lunch, and dinner. Review of resident #10's Nutrition Care Plan, dated 7/10/20, showed, My oral intake improves when nursing assists me with meals. To help self-feeding, I receive red foam over my utensil handles. |
| F 0837<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.**<br><br>Based on observation, interview, and record review, the facility's governing body failed to provide adequate building maintenance and repairs. This failure has the potential to affect all residents, staff, and visitors of the facility. Findings include: During an observation on 07/27/20 at 12:30 p.m., an internal and external inspection of the facility was performed. Internally, several areas within the facility were observed to have sustained water damage. Externally, the facility's roof, soffits, and fascia were observed to be in extremely poor condition, and severe water damage, possible mold growth, and rodent infestation were noted. During an interview on 07/27/20 at 1:32 p.m., staff member P stated he began working for the facility in September of 2019. He stated the roof had been an ongoing issue and he has made several repairs to it since beginning his employment. Staff member P stated he has been securing quotes from multiple contractors to have the roof, soffits, and all the fascia replaced. He stated he cannot proceed with hiring a contractor until, The powers that be approve it. During an interview on 07/27/20 at 2:13 p.m., staff member A stated he has worked at the facility for two and a half years. He stated, I've been asking for a new roof since I started. He stated staff member P had been securing quotes to have the roof, soffits, and fascia replaced. He stated the facility also had quotes performed back in 2018, but nothing was completed at that time. Staff member A stated members from the corporate office came out to observe the roof a couple of months ago. He stated, They know it's bad, and there is money set aside for the repairs. Staff member A stated he anticipates having a new roof by the end of the year. During an interview on 07/28/20 at 10:27 a.m., resident #14 stated she had been a resident of the facility for almost five years. She stated, Are they finally going to fix that Eve? It's been like that since I've been in this room. Resident #14 stated she had asked to have the soffits and fascia repaired in the past. She stated the falling soffits and fascia were restricting her outside view. Record review of Home Roof Project, prepared on 06/22/18 showed, Many of the lower edges have been fabricated to divert water into scuppers rather than allowing water to flow directly into a proper water collection system. In the winter heavy ice damning has |

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| F 0837<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 2)<br>occurred due to this .Excessive water and ice have deteriorated the membrane to the point where it is simply allowing water to pour through the mesh scrim sheet .The damning of water here has caused enough damage that the soffit, fascia, and trusses have begun to fall. Dirt stains show where ponding water occurs .Drain inserts are rusted and past the functioning life span .Every single roof facet has multiple signs of water and moisture damage .Because of this massive amount of moisture in the roofing system all current roofing materials must be removed so that wood decking may be inspected, removed, and replaced if any rot or mold is found .Recreation gazebo and Main Entrance walkway roof are extremely deteriorated and pose significant danger to anyone below as debris and roofing materials have begun to be removed due to the wind. Record review of Roof Assessment and Proposed Solution, prepared on 06/05/20 showed, The roof is failing and in need of replacement .The field of the roof has clearly reached the end of its life cycle. Previous repairs have been made and further attempts to repair this roof are not recommended .The details of the roof are in poor condition and are currently allowing for moisture to enter the roof system .The insulation has become saturated in identified areas. This moisture-laden material needs to be removed and replaced immediately to prevent further costly deterioration. Record review of Management Report, prepared on 07/08/20 showed, This roof is rated an F. It has reached the end of its usefulness. There are multiple areas where the membrane has deteriorated to a point the inner layer of scrim is showing through. There are areas of soffit and fascia that are falling from the building. On 07/28/20 at 12:36 p.m., the following email was received from staff member EE, I was informed by our Administrator at (facility name), (staff member A), that there have been questions about the needed roof repairs at the facility. I want to assure you that we understand the urgent need for a solution and are meeting this week to decide on a contractor. We received our final bid last week on Thursday, and are meeting this week to select a contractor to install a new roof and replace all of the facility's fascia and soffit. The funding for the roof replacement has already been secured and we expect work to begin very soon. Refer to F0921 and F0925. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br><br>Based on observations, interviews, and record review, the facility staff failed to adhere to infection control practices by not wearing face masks appropriately; and failed to perform appropriate hand hygiene while providing perineal care for 1 (#1) of 14 sampled residents. These failures had the potential to affect all residents in the facility. Findings include:<br>1. During an observation on 7/27/20 at 12:13 p.m., the surveyors entered the facility. Staff member C and staff member D were observed sitting in the front reception, not wearing their face masks. During an observation on 7/27/20 at 12:13 p.m., staff member U walked by the front reception area with her mask on, over her mouth and under her nose. Staff member U did not have her nose covered. During an observation on 7/27/20 at 1:19 p.m., staff member D was observed in the front reception area. She was not wearing a mask. Her mask was observed sitting on the desk in front of her. During an interview on 7/27/20 at 1:22 p.m., staff member D stated she was supposed to wear a mask when she was within six feet of a resident of the facility. She stated, When I am around other staff, wearing a mask is at my own discretion. During an observation on 7/27/20 at 2:00 p.m., staff members I and H were sitting at the desk on the 600 hall. Staff member I was working on the computer. Staff member I had her mask under her chin not covering her mouth and nose. During an interview on 7/27/20 at 2:06 p.m., staff member H stated staff were to wear masks at all times. During an interview on 7/27/20 at 2:13 p.m., staff member A stated, All staff, at all times, in all areas of the facility must wear masks. He stated, Business office staff are included. Everyone must wear a mask. During an interview on 7/27/20 at 2:45 p.m., staff member R stated that the staff have been trained to wear a mask at all times covering their nose and mouth. During an observation on 7/28/2020 at 2:06 p.m., staff member C was observed sitting at a desk in the front reception area. His face mask was observed hanging from his right ear and not covering his face. During an observation and interview on 7/27/20 at 12:32 p.m., staff member U was sitting on a chair at the end of hall with her mask under her nose. Staff member U stated residents and staff were to wear their masks in all areas of the building. Staff member U stated her mask was supposed to cover her face fully. During an interview on 7/28/20 at 8:00 a.m., staff member T stated the housekeeping staff are to wear their mask at all times and to cover their nose and mouth. She stated if the house keeping staff do not wear the mask properly, they would receive corrective action. Review of the facility April 2020 All Staff Agenda, showed infection control, including Covid-19, listed on the agenda. Review of the documentation for a facility staff meeting titled, May 2020 All Staff Agenda, showed . Reiteration of PPE or isolation; and continuation for wearing a mask during work hours 2. During an observation on 7/27/20 at 12:23 p.m., the kitchen was inspected. Staff member E was observed standing near the cooler with a resident food tray. He did not have a mask on. During an observation on 7/27/20 at 12:27 p.m., staff member F was observed standing in the kitchen, serving and preparing resident room trays for lunch. He was observed wearing a yellow surgical mask over his mouth; his nostrils were uncovered. During an interview on 7/27/20 at 12:28 p.m., staff member G stated he was the Dietary Manager and responsible for overall operations and staff in the kitchen. He stated, Kitchen staff must wear masks at all times, especially while serving food. Staff member G explained staff are supposed to make sure that the masks cover their mouth and nostrils. He stated, I'm constantly telling everyone to cover their nose. Record review of facility training, New COVID-19 Policies for Dietary Staff on 07/28/20 showed, Masks must always be worn in kitchen and during meal/snack delivery.<br><br>3. During an observation on 7/28/20 at 12:55 p.m., staff members L and M provided pericare to resident #1 after an incontinent bowel episode. Staff member L gathered wipes, a clean brief, moisture barrier cream, and put her gloves on. Staff member M washed her hands and put her gloves on. Staff member L raised the bed with the controller, pulled the covers back, and removed the pillows from under resident #1. Both staff members explained the procedure to resident #1. Staff members L and M assisted resident #1 to roll over onto her right side. Staff member M held onto resident #1 while staff member L tucked the soiled brief and incontinent pad under resident #1's side, and provided perineal care. Staff member L obtained a clean incontinent pad from resident #1's wheel chair and placed it under her. Staff member L obtained the clean incontinent brief and placed it under resident #1, and then applied moisture barrier cream to resident #1's buttocks. Staff members L and M assisted resident #1 to roll over onto her back. Staff members L and M removed the soiled brief and incontinent pad. Staff member M held onto the soiled products with one hand, while staff member L continued to provide perineal care. Staff member L opened the drawer of the night stand, obtained more wipes, and provided more perineal care for resident #1. Staff member L secured the clean brief. Staff member M then placed the soiled products in the garbage, removed her gloves, and washed her hands. Staff member L removed her gloves, gathered the garbage, and placed a new garbage bag in the garbage can. Staff member L and M then repositioned resident #1 in her bed, gave her the call light, obtained the garbage, and left the room. During an interview on 7/29/20 at 8:05 a.m., staff members CC and DD stated when providing perineal care, staff should wash your hands, put gloves on, remove soiled gloves, wash your hands, put new gloves on, and then finish cares. To summarize, soiled gloves should be changed in between dirty and clean tasks. Review of the facility's policy titled, Infection Control Guidelines for All Nursing Procedures, revised 8/2012, showed: Employees must wash their hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct contact with residents; when hands are visibly dirty or soiled with blood or other body fluids; after contact with body fluids; after removing gloves . In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub . before and after direct contact with residents . before moving from a contaminated body site to a clean body site during resident care after removing gloves. |
| F 0921<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to: a) maintain access to portable fire extinguishers in accordance with NFPA 10 Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.3.1.; b) ensure accessibility to a manual fire alarm pull station in accordance with NFPA 101, 2012 Edition, Section 9.6.2.7.; c) maintain the electrical system in accordance with NFPA 70 National Electric Code, 2011 Edition, Article 110-12(B).; d) ensure fire/smoke barrier doors located in the fire/smoke partitions were maintained per NFPA [PHONE NUMBER], Section 8.4.3.4 and NFPA 80 Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 6.3.1.7.1.; e) ensure an exit sign was located above an exit door in accordance with NFPA 101, 2012 edition, section 7.10.1.9.; f) ensure proper sprinkler maintenance in |

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| F 0921<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 3)<br>accordance with NFPA [PHONE NUMBER] and NFPA 25-2011, Sections 5.2 and 5.2.1.1.1, 5.3.2.1, and table 5.1.1.2.; g) keep the means of egress open to full and instant use in accordance with NFPA 101, 2012 Edition, Sections 7.1.10.1 and 19.2.3.4(5).; h) provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public; and i) maintain oxygen cylinders per NFPA 99-2012, Section 11.6.2.3. These deficiencies affect all smoke compartments of the facility.<br>Findings include: 1. During an observation on 7/27/20 at 12:20 p.m., the main dining room was inspected. A dining table was observed, approximately four feet in length, placed up against the wall, and blocking access to the portable fire extinguisher in the room. 2. During an observation on 7/27/20 at 12:23 p.m., the kitchen was inspected. The K tank in the room was blocked from easy access by a large garbage can being stored in front of it. The manual fire pull station on the back wall and manual pull station for the kitchen hood were both obstructed by various items being stored in front of them. 3. During an observation on 7/27/20 at 1:13 p.m., the 400-wing nursing station was inspected. A large side table with decorative items was observed, placed directly in front of two electrical panels on the wall. 4. During an observation on 7/27/20 at 1:25 p.m. the 200-wing smoke doors were inspected. The doors were closed and a gap greater than  was observed in the bottom portion of the door. 5. During an observation on 7/27/20 at 1:27 p.m., the 200-wing emergency exit door was inspected. The door was missing illuminated exit signage directing all persons in the area to the means of egress. 6. During an observation on 7/27/20 at 1:28 p.m., the 200-wing was inspected. Several sprinkler heads throughout the hall were observed, missing their escutcheon rings. 7. During an observation on 7/28/20 at 8:08 a.m., the exterior of the facility was inspected. Several large overgrown shrubs were observed growing over the sidewalks around the perimeter of the building, blocking the means of egress to the public way. 8. During an observation on 7/28/20 at 8:57 a.m., a walk around of the exterior of the facility was conducted. Outside of resident room [ROOM NUMBER], the soffits and fascia were observed tearing away from the roof. Severe water damage was present. 9. During an observation on 7/28/20 at 8:59 a.m., a walk around of the exterior of the facility was conducted. Outside of resident room [ROOM NUMBER], a large portion of the soffit was observed missing from the exterior of the facility. Several areas were noted with severe water damage and possible mold growth. Rodent feces were present. During an interview on 7/28/20 at 9:00 a.m., staff member P stated the opening was, About my height, I'm just over six feet tall. 10. During an observation on 7/28/20 at 9:02 a.m., a walk around of the exterior of the facility was conducted. Outside of resident room [ROOM NUMBER], the fascia was observed missing from the exterior of the facility and the soffit was tearing away from the building. Severe water damage was present. 11. During an observation on 7/28/20 at 9:05 a.m., a walk around of the exterior of the facility was conducted. Outside of resident rooms [ROOM NUMBERS], the soffits were observed tearing away from the building. 12. During an observation on 7/28/20 at 9:08 a.m., a walk around of the exterior of the facility was conducted. At the exterior corner of the 400 and 500 wings, the fascia was observed missing. Wet wood was exposed, and severe water damage was present. 13. During an observation on 7/28/20 at 9:09 a.m., a walk around of the exterior of the facility was conducted. A large piece of soffit was observed, approximately five feet in length, lying on the ground. The soffit had fallen from the exterior of the building. Severe water damage was present. During an interview on 7/28/20 at 9:10 a.m., staff member P stated he was not aware that the soffit had fallen. He stated, It must have fallen recently because it's still on the ground. Staff member P stated the exposed area of the building was, At least five feet long. 14. During an observation on 7/28/20 at 9:12 a.m., a walk around of the exterior of the facility was conducted. The exterior of the building outside of resident rooms 517, 516, 510, 509, 505, and 504 we observed. Several holes and gaps were noted in the soffits and water damage was present. 15. During an observation on 7/28/20 at 9:21 a.m., a walk around of the exterior of the facility was conducted. The exterior of the building outside of resident room [ROOM NUMBER] was observed. The soffits and fascia were tearing away from the building and drooping greater than two feet. Severe water damage was present. 16. During an observation on 7/28/20 at 9:24 a.m., a walk around of the exterior of the facility was conducted. Outside of resident rooms [ROOM NUMBERS], a large portion of the soffit, approximately six feet in length, was observed missing. The missing soffit was observed propped against the exterior of the building on another wing. Severe water damage and rodent feces were observed. During an interview on 7/28/20 at 9:25 a.m., staff member P stated he observed the rodent feces surrounding the opening in the exterior of the building. He stated, Surprisingly, there's been no complaints of rodents. 17. During an observation on 7/28/20 at 9:26 a.m., a walk around of the exterior of the facility was conducted. The exterior of the building outside of the main dining room and resident rooms [ROOM NUMBERS] were observed. Holes in the soffits were noted, as well as several areas where the soffits and fascia were tearing away from the exterior of the building. Water damage was present. 18. During an observation on 7/28/20 at 9:58 a.m., a walk around of the interior of the facility was conducted. Inside the conference room, six ceiling tiles were observed with water damage. Above the ceiling tiles, water damage to the roof deck was observed. During an interview on 7/28/20 at 9:59 a.m., staff member P stated the water damage to the ceiling tiles was a result of one of the roof leaks the facility had sustained. He stated, I patched it in early March. 19. During an observation on 7/28/20 at 10:01 a.m., a walk around of the interior of the facility was conducted. Inside the dining room, seven ceiling tiles were observed with water damage. During an interview on 7/28/20 at 10:02 a.m., staff member P stated the water damage was sustained in early March during the same time that the conference room ceiling sustained water damage. 20. During an observation on 7/28/20 at 10:02 a.m., a walk around of the interior of the facility was conducted. The exterior wall in the dining room was observed, covered with streaks of brown water stains. During an interview on 7/28/20 at 10:03 a.m., staff member P stated the water stains were a result of constant patching of the facility's gutter system. He stated he had tried to wash the stains off the wall several times, but they keep coming back and won't scrub off. 21. During an observation on 7/28/20 at 10:04 a.m., a walk around of the interior of the facility was conducted. The storage area, across from resident room [ROOM NUMBER] was inspected. A ceiling tile was removed near the exterior wall. The soffit was missing on the exterior of the building, exposing the interior of the building, and the wet sprinkler piping to external elements. Rodent feces and severe water damage were observed. 22. During an observation on 7/28/20 at 10:32 a.m., a walk around of the interior of the facility was conducted. Resident room [ROOM NUMBER] was inspected. A ceiling tile was removed near the exterior wall. The soffit was missing on the exterior of the building, exposing the interior of the building, and the wet sprinkler piping to external elements. Rodent feces and severe water damage were observed. 23. During an observation on 7/28/20 at 12:49 p.m., the roof was inspected. Standing water was observed in addition to growing vegetation. During an interview on 7/28/20 at 12:50 p.m., staff member P stated the roof at the facility needed to be replaced. He stated he has received several bids; however, he was waiting for permission to proceed with the work from the corporate office. Staff member P stated the roof was flat and holds water after rainstorms. 24. During an observation on 7/29/20 at 10:16 am, the 500 wing was inspected. Six of the thirteen ceiling mounted light fixtures were observed with burnt out bulbs. 25. During an observation on 7/29/20 at 10:30 a.m., the 400 wing was inspected. Four of the six ceiling mounted light fixtures were observed with burnt out bulbs. 26. During an observation on 7/29/20 at 11:10 a.m., twenty-four portable oxygen e-tanks were observed sitting on a cart outside of the front office reception area. The oxygen tanks were not being supervised or attended to by any staff members. The e-tanks were again observed unaccompanied at 1:10 p.m During an interview on 7/29/20 at 1:11 p.m., staff member C stated that he was not sure why the e-tanks were being stored in front of the reception area, however he believed that the oxygen contractor was on-site and was going to be putting them away. 27. During an observation on 7/29/20 at 1:13 p.m., the front exterior entrance was inspected. Two sprinkler heads were observed, loaded with dust and debris. 28. On 7/29/20 at 2:00 p.m., an interior and exterior inspection of the facility was conducted in conjunction with the City of Great Falls Fire Captain and the City of Great Falls Building Official. All above noted deficiencies were inspected during this time. During an interview on 7/29/20 at 2:08 p.m., the City of Great Falls Fire Captain stated his department was not responsible for enforcing building code requirements. He observed the above deficiencies noted deficiencies and stated that his two primary concerns were: a) The wet sprinkler system being compromised due to the internal wet sprinkler piping being exposed to external elements; b) The two unprotected areas with the large openings in the ceiling, which expose the inside of the facility to the outside. He stated in the event that there was to be a fire within the facility, oxygen from the outside would fuel the fire. During an interview on 7/29/20 at 2:50 p.m., the City of Great Falls Building Official stated the facility was, Very cheaply built. He stated the building was both habitable and structurally sound; however, the extent of the water damage was a serious concern and there was possible mold growth present. He stated, The building is compromised, and failure to repair the identified issues would result in the building getting worse. He acknowledged the presence of rodent feces inside the facility and stated his department was not responsible for enforcing maintenance and repair deficiencies. |
| F 0925<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** |

| 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 _____ | **07/30/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PARK PLACE TRANSITIONAL CARE AND REHABILITATION** | **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) |
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| F 0925<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to maintain an adequate pest control program to prevent rodents from entering the facility. This deficient practice had the potential to affect all residents residing in the 400 and 500 wings of the facility. Findings include: During an observation on 7/28/20 at 10:04 a.m., the sitting room, across the hall from resident room [ROOM NUMBER], was inspected. A ceiling tile was removed from the ceiling, and an opening in the exterior wall of the facility was observed. Rodent feces were observed on several of the ceiling tiles. During an observation on 7/28/20 at 10:32 a.m., resident room [ROOM NUMBER] was inspected. A ceiling tile was removed from the ceiling and an opening in the exterior wall of the facility was observed. Rodent feces were observed on several of the ceiling tiles. During an interview on 7/28/20 at 10:34 a.m., staff member P stated he was not aware that the exterior of the facility was open to the interior. He stated he could see the rodent feces present in the area. Refer to 0921, Safe/Functional/Sanitary/Comfortable Environment, for additional information. |