

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/26/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/21/2021
NAME OF PROVIDER OR SUPPLIER AVANTARA OF BILLINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 2115 CENTRAL AVE BILLINGS, MT 59102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>A facility reported incident survey was completed on 7/21/21. The facility census on entrance was 102.</p> <p>DEFICIENCIES CITED:</p> <p>Past-noncompliance deficient practices were cited for the facility reported incident with Intake number: MT51093</p> <p>Glossary:</p> <p>AMR American medical response BP blood pressure CPR cardiopulmonary resuscitations CNA certified nursing aide DNR do not resuscitate EHR electronic health record L liter O2 oxygen Resp respirations Temp temperature</p>	F 000			
F 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record reviews the facility failed to follow the facility's Policy and Procedure on how to retrieve resident's POLST document resulting in 1 resident receiving CPR from the ambulance service when the resident</p>	F 658	Past noncompliance: no plan of correction required.	8/3/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/03/2021

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 658	<p>Continued From page 1</p> <p>had a DNR order for 1 (#1) out of 5 sampled residents. Findings include:</p> <p>During an interview on 7/21/21 at 2:04 p.m., staff member A stated, resident #1 was having difficulty breathing throughout the night. Staff member D gave the resident supplemental oxygen and called staff member C. An order was given to send resident #1 to the Emergency Department. As the ambulance crew arrived, a staff member reported the resident was not breathing. Staff member D did not perform CPR because staff member D knew the resident had a DNR order. The ambulance crew requested the POLST and staff member D could not find it. The ambulance crew started CPR as the doctor was called. The Ambulance crew ceased CPR after a verbal confirmation from the doctor that the resident had a DNR order. Staff member A stated the POLST was later found "on the desk and not in the POLST book." Staff member A stated, "[staff member D's name] did not remember that the POLSTs are all scanned into the [Name of EHR System] under the Miscellaneous tab."</p> <p>During an interview on 7/21/21 at 2:55 p.m., staff member B stated, the POLST is directly scanned after the order from the doctor so it should always be available in the Miscellaneous tab in [Name of EHR System]. Then there is a hard copy of the POLST that should be in a POLST binder in each unit. Nurses should know where that book is located as well as where it is in the resident's EHR. Resident #1 just moved units so the hard copy of the POLST had not been moved over to that specific unit's POLST book. There is not necessarily a designated person to move the POLST over if a resident switches units.</p>	F 658			

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F 658	<p>Continued From page 2</p> <p>During an interview on 7/21/21 at 3:00 p.m. staff member B stated "[Staff member D's name] knew where the POLST was located. I think there was just a lot going on and she was panicking. She was working on getting him sent to the hospital. I don't think she thought about where to look for the POLST. Everything happened so fast and she was overwhelmed. He stopped breathing right when the ambulance crew walked in, so she didn't know yet that he wasn't breathing. The ambulance needs a verbal confirmation from the hospital to stop CPR. They can't just look at a Doctors order and stop CPR they specifically need the POLST." Staff member B stated that unit managers do a lot of the training on the floor with the new nurses. Staff member B stated, "Once [staff member D's name] orientated with the floor nurse, the unit manager would have shown [staff member D's name] where to find the policies and procedures and where the advance directives are located as well as the POLST." Staff member B stated staff member F would have done most of staff member D's training with her and that she would have been shown where policies and procedures are as well as where the POLST was located.</p> <p>During an interview on 7/21/21 at 3:20 p.m. staff member E stated, "when I train and orient new nurses I want to make sure they know where to find things in [Name of EHR System]. I like to give specifics with residents, so they know them well. I train them with risk management, and train on where to find documents in [Name of EHR System] such as documents they would need to transfer a resident to the emergency room. Where to chart vitals, face sheet, progress notes and where to document in progress notes." Staff member E stated, "I specifically train on where to</p>	F 658			

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F 658	<p>Continued From page 3</p> <p>find advance directives in the [Name of EHR system]. You find advance directives in [Name of EHR System]. You go to Miscellaneous tab and its listed in there. After I am done training nurses, I report back with [staff member B's job title] with how the new hired nurses are doing. [staff member B's name] and I discuss what more we can do to help them become better orientated."</p> <p>During an interview on 7/21/21 at 3:52 p.m., staff member F stated, he trained with a lot of different people but mostly the unit managers and staff member B. Staff member F stated the unit managers help the newly hired nurses get orientated to the floor. Staff member F stated, "If I need to find policies and procedures, I can find them on the computer. There is also a hard copy of them as well. In orientation, the unit managers train on where to find POLST and advance directives. They have a binder at the nurse's station with the hard copies of POLSTs for that unit. To find them in [Name of EHR System] I would look under the miscellanies tab and look for the newest one that is in the system." Staff member F stated, "I have never had an issue trying to locate a POLST for a resident at this facility."</p> <p>During an interview on 7/21/21 at 3:24 p.m. staff member A stated during new hire orientation we have this document titled "How to Retrieve Advanced Directive from [name of EHR System]" explaining where to find the POLST. This is in the training for all new hires.</p> <p>Review of facility document titled "How to Retrieve Advanced Directive from [Name of EHR System]" showed, "When a resident is in any distress, the POLST must be presented at</p>	F 658			

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F 658	<p>Continued From page 4</p> <p>bedside immediately. Nursing MUST have someone capable of retrieving POLST do so immediately while they attend to the resident. The original POLST is available in the binder located behind the nurse's station. If for some reason it is not in the book, or if there is another reason it cannot be located, it is also scanned into the medical record. [Name of EHR system], select your resident from the clinical tab, then go to the misc tab and click it. Below the misc tab is "Sort By:" choose category. One of the first categories is Advanced Directives, there you will find scanned POLST. If there is more than one, make sure you are printing the most recent POLST. Again, this MUST be at bedside ...AMR, or any other first responder cannot, and will not take a verbal from staff. They have to see the POLST."</p> <p>Review of resident #1's "Montana Provider Orders For Life-Sustaining Treatment (POLST)" showed, "Section A, Treatment Options: If a patient does not have a pulse and is not breathing: Do Not Attempt Resuscitation (DNR)"..." The date of this form was 3/29/21.</p> <p>Corrective Measures:</p> <p>Review of the facility's documents showed the facility provided education to all staff members on 6/22/21. This education included the following: The POLST must be readily available, and where to find the hard copy of each resident's POLST form. Where to find resident's POLST information in the EHR system, and education about how the AMR or any other first responder cannot take verbal information from staff, they must see the POLST form.</p> <p>The facility conducted audits of all resident's</p>	F 658			

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F 658	Continued From page 5 medical record to ensure all POLST forms were scanned and uploaded into the resident's EHR under the Miscellaneous tab and that all residents had a hard copy of the POLST form in the binder for their unit. This was completed on 6/23/21.	F 658			
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure physician's orders for a resident's POLST, with a DNR status, was followed for 1 (#1) of 5 sampled residents. Findings include: During an interview on 7/21/21 at 2:04 p.m., staff member A stated, resident #1 was having difficulty breathing throughout the night. Staff member D gave the resident supplemental oxygen and called staff member C. An order was given to send resident #1 to the emergency department. As the Ambulance crew arrived a staff member reported that the resident was not breathing. Staff member D did not perform CPR because staff member D knew the resident had a DNR order. The ambulance crew requested the	F 678	Past noncompliance: no plan of correction required.	8/3/21	

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F 678	<p>Continued From page 6</p> <p>POLST and staff member D could not find it. The Ambulance crew started CPR as the doctor was called. The Ambulance crew ceased CPR after a verbal confirmation from the doctor that the resident had a DNR order. Staff member A stated the POLST was later found, "on the desk and not in the POLST book." Staff member A stated, "[staff member D's name] did not remember that the POLSTs are all scanned into the [name of EHR System] system under the miscellaneous tab."</p> <p>During an interview on 7/21/21 at 2:55 p.m., staff member B stated, the POLST was directly scanned after the order from the doctor so it should always be available in the Miscellaneous tab in the resident's EHR. Then there is a hard copy of the POLST that should be in a POLST binder in each unit. Nurses should know where that book is located as well as where it is in the resident's EHR. Staff member B stated resident #1 just moved units so the hard copy of the POLST had not been moved over to that specific unit's POLST book. Staff member B stated, there was not necessarily a designated person to move the POLST over if a resident switches units.</p> <p>Review of resident #1's "Montana Provider Orders For Life-Sustaining Treatment (POLST)" showed..."Section A, Treatment Options: If a patient does not have a pulse and is not breathing: Do Not Attempt Resuscitation (DNR)"..." The date of this form was 3/29/21.</p> <p>Review of resident #1's "Progress Note" dated, 6/22/21 at 00:30 showed, "Resident turned call light and stated "I can't breath." Upon entering resident's room resident was coughing and mouth breathing, skin was warm and dry to touch. He</p>	F 678			

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F 678	<p>Continued From page 7</p> <p>denied pain. O2 Sats 77% on room air. Nebulizer Treatment was given and O2 via Nasal cannula was applied at 3L/min per concentrator. His O2 sats did come up to 90%. Head of bed was elevated. BP 133/92 Pulse 107. Temp 97.5 R 24."</p> <p>Review of resident #1's "Progress Note" dated, 6/22/21 03:00 showed, "Resident turned his call light on and again was having difficulty breathing. O2 Sats 88% and increased to 4L/min and Oxygen Sats became 90% but he had to be reminded to breath through his nose. He was pale but not diaphoretic. Blood Sugar was obtained with result of 219. Bp 16/91 P-90 and regular. Tempt 97.5 Oxygen sats 90% on 4L/min O2. Resp 28. He remained alert and able to answer questions appropriately. Lung sounds diminished with wheezing to upper lobes."</p> <p>Review of resident #1's "Progress Note" dated, 6/22/21 at 03:15 showed, "Notified [staff member C's name] and was given an order to send to [Name of Emergency Department] for evaluation."</p> <p>Review of resident #1's "Progress Note" dated, 6/22/21 at 3:32 showed, "Called AMR for Transfer to the ED at [Name of Hospital]."</p> <p>Review of resident #1's "Progress Note" dated, 6/22/21 at 3:55 showed, "Resident was found by CNA not to be breathing. Ambulance staff arrived and started to perform CPR before learning of resident's code status of DNR."</p> <p>During an interview on 7/21/21 at 3:24 p.m., staff member A stated, "during new hire orientation we have this document titled "How to Retrieve Advanced Directive from [Name of EHR System]"</p>	F 678			

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F 678	<p>Continued From page 8 explaining where to find the POLST. This is in the training for all new hires."</p> <p>Review of the facility's document titled "How to Retrieve Advanced Directive from [Name of EHR System]" showed, "When a resident is in any distress, the POLST must be presented at bedside immediately. Nursing MUST have someone capable of retrieving POLST do so immediately while they attend to the resident. The original POLST is available in the binder located behind the nurse's station. If for some reason it is not in the book, or if there is another reason it cannot be located, it is also scanned into the medical record. In [Name of EHR System], select your resident from the clinical tab, then go to the misc tab and click it. Below the misc tab is "Sort By:" choose category. One of the first categories is Advanced Directives, there you will find scanned POLST. If there is more than one, make sure you are printing the most recent POLST. Again, this MUST be at bedside ...AMR, or any other first responder cannot, and will not take a verbal from staff. They have to see the POLST."</p> <p>Corrective Measures:</p> <p>Review of the facility's documents showed the facility provided education to all staff members on 6/22/21. This education included the following: The POLST must be readily available, and where to find the hard copy of each resident's POLST form. Where to find resident's POLST information in the EHR system, and education about how the AMR or any other first responder cannot take verbal information from staff, they must see the POLST form.</p> <p>The facility conducted audits of all resident's</p>	F 678			

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F 678	Continued From page 9 medical record to ensure all POLST forms were scanned and uploaded into the resident's EHR under the Miscellaneous tab and that all residents had a hard copy of the POLST form in the binder for their unit. This was completed on 6/23/21. Upon interviewing staff members it was found that the staff knew where to find resident's POLST documentation in the EHR and the POLST binder located on each unit.	F 678			