STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275123	A. BUILDING _____ B. WING _____	C 01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE CLIFF MANOR	1415 YELLOWSTONE RIVER RD BILLINGS, MT 59105

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F 000	INITIAL COMMENTS	F 000		

A Recertification survey was completed by the Department of Health and Human Services, Office of Inspector General, Certification Bureau, on 1/20/22. Facility Reported Incidents were investigated during the survey.

The facility census on entrance was 35.

DEFICIENCIES CITED:
Refer to FORM CMS-2567; Event ID: TUQ911 for findings.

Deficient practices were cited for the Recertification survey.

Deficient Practices were cited for Facility Reported Incident(s) with Intake Number(s): MT00051809, MT00051814

DEFICIENCIES NOT CITED:
Refer to FORM CMS-2567; Event ID: 5V6011 for findings not cited.

Deficient Practices were NOT cited for Facility Reported Incident(s) with Intake Number(s): MT00051808, MT00051811, MT00051812, MT00051820, MT00051823

Glossary

CNA	Certified Nurse Assistant
IDT	Interdisciplinary Team
MAR	Medication Administration Record
RTA	Resident Trust Account
SBAR	Situation Background Assessment Recommendation
TAR	Treatment Administration Record

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

Electronically Signed | 02/12/2022

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F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account,	F 567		2/10/22

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F 567	Continued From page 2 interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain resident's authorization for opening a resident trust account and deposit of a resident stimulus check into the account for 1 (#8) of 2 sampled residents. Findings include: During an interview on 1/18/22 at 3:24 p.m., resident #8 stated the facility had opened her mail and deposited a government stimulus check without her knowledge or permission. Resident #8 filed a missing check claim with the Treasury Department. The Treasury Department notified resident #8 the stimulus check had been cashed by the facility. Resident #8 then notified the facility administrator regarding the missing funds. The funds were located in the Resident Trust Account and refunded to resident #8. The resident was unable to provide the incident dates. Resident #8 stated she did not trust the facility to be honest about her funds. During an interview on 1/19/22 at 1:06 p.m., staff member B stated resident #8's funds were being handled at the corporate level because the facility did not have business office staff at that time. Staff member B said she was not sure how the account was opened or who had deposited resident #8's money into the account. Record review of resident #8's "Grievance/Concern Report Form," dated 5/17/21, showed "Stimulus money was deposited into the RTA without [resident #8's] consent. [Resident #8] wanted the "cash."... Interim administrator is getting cash for [resident #8's] RTA on 5/18/21. Cash provided to [resident #8].	F 567	1. Resident #8 was refunded her Treasury Stimulus check from her resident trust account on 5/18/2021 in the amount of $1,400.02 by the facility. 2. Any resident who is admitted to the facility has the potential to be affected by this deficient practice, if the facility was not given consent to manage the residents personal funds. Moving forward, the facility will review the resident's admission agreement to identify if the resident has given authorization to the facility to manage their funds. The facility will ensure that if a resident wishes the facility to manage the funds a signed written agreement will be maintained. 3. On or before 2/4/2022, the Corporate Regional Vice President of Operations will educate the Business Office Manager and Facility Administrator on Managing Residents funds. This will include reviewing the residents written admission agreement and signed agreement for the management of resident's funds. 4. A resident funds audit will be completed to track this information for deposits and withdrawals for residents who have elected not to have the facility manage their funds. These audits will be completed 3 times per week Monday through Friday for 4 weeks and then once weekly for 2 months or as deemed necessary by the QAPI team. 5. The results of these audits will be shared with the QAPI team on 2/10/2022. Further action will be completed as	

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F 567	Continued From page 3 ..." Record review of resident #8's "Transaction History" report, dated 1/1/21 through 1/31/22, showed $1400.00 was deposited on 4/26/21. On 5/18/21, a "Stimulus cash out" was made for $1400.02. Record review of resident #8's copy of the "United States Treasury" check, showed a check made out to resident #8 in the sum of $1400.00. The back of the check is stamped "...Pay to the order of Wells Fargo Bank. ..." No signature of endorsement from resident #8 was on the check. Record review of "Resident Trust Funds Montana," from resident #8's facility admission packet, dated 4/27/20, showed: Residnt #8 selected to maintain and manage my own funds and selected no to designating the facility to hold the resident's funds in the Residnt Trust Fund Account. Record review of the facility's "Trust Account Authorization Policy," dated 8/19/21 showed, "...Written authorization must be obtained to open and maintain resident funds in the facility resident trust account. ..."	F 567	deemed necessary by the QAPI team. 6. Compliance will be met by 2/10/2022.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		2/10/22

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F 600	Continued From page 4 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a resident was free from verbal abuse by a staff member; failed to monitor a staff member after an abuse allegation was substantiated for 1 (#19) of 1 sampled resident; and the facility failed to protect residents from verbal and physical sexual contact by resident #19 and failed to monitor and track resident #19's sexual behaviors for 2 (#s 25 and 26) of 2 sampled residents. Findings include: 1. Review of resident #19's Internal Investigation Form, dated 10/3/21, showed an incident occurred in resident #19's room at 4:00 p.m. Staff member L heard staff member I say, "I am in charge and sit your ass down in your wheelchair" to resident #19. Staff member I was suspended and a police report was filed. Review of staff member I's handwritten statement regarding her conduct with resident #19, not dated, showed" ...I asked/instructed that I need him to please grab the bar to stand up so we could get him on the toilet He grabbed the bar and stood up I then helped get his pants down so he could transfer to the toilet he said, 'Now what do you want me to sit my ass back in the chair?' In response to how he questioned I stated no I want you to sit your ass over there on the toilet so	F 600	1. Staff member I was suspended, and an investigation was initiated. Staff member I was re-educated on Abuse/Neglect and Residents Rights prior to returning to work prior to the survey. Resident #19 was moved to another table away from resident #25's table prior to the survey. Resident #19 was moved to another room away from resident #26 prior to the survey. Moving forward, any staff member with an allegation of Abuse/Neglect who is permitted to return to work will be monitored for 1 week following the allegation, and then twice weekly for one month. Moving forward, any resident who exhibits sexual behaviors will have sexual behavior monitoring attached to their TAR. The resident exhibiting sexual behaviors will also have their care plan updated accordingly. 2. Residents who exhibit sexual behaviors have the potential to be affected by this practice. Any resident has the potential to be affected by staff members abusing or neglecting them. The facility will include sexual behavior monitoring on the residents' TAR to monitor for behaviors. The facility will also ensure that the	

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F 600	Continued From page 5 we can change you please. I did use the word ass only because I responded back to him using the exact word as he used." [sic] During an interview on 1/19/22 at 3:00 p.m., staff member C stated the employee was suspended for the investigation. Staff member C stated staff member I was educated on abuse prevention and resident's rights. Staff member C stated the facility notified the police. Staff member C stated the situation was more of a misunderstanding than deliberate abuse. Staff member C stated "It didn't feel like she was being malicious, he was talking to her like that, so she just used the same language." Staff member C stated resident #19 could not recall the event. Staff member C stated the facility did not do any monitoring of staff member I after the incident because the facility did not want to "single her out." He stated if there had been additional incidents staff member I would of been monitored. Staff member C stated when residents were interviewed, direct questions regarding staff member I's resident interactions were not asked. Staff member C stated generalized questions allowed the facility to determine if any abuse was occurring, rather than just with staff member I. During a telephone interview on 1/19/22 at 4:09 p.m., staff member A stated he completed the investigation for the Facility Reported Incident, dated 10/3/21, involving staff member I and resident #19. Staff member A stated he only interviewed staff member I, staff member L, and one previous social services staff member because it was an "isolated incident." Staff member A stated the reason he substantiated the incident as abuse was because staff member I used the word "ass." Staff member A stated this	F 600	residents who exhibit behaviors will have their care plan updated appropriately. The facility will ensure that any resident who is affected by another residents sexual behaviors are protected, and that their care plan and interventions are put into place to protect their safety. Resident #19's care plan was updated to state, "staff to set boundaries with resident as a way to minimize his inappropriate sexual behaviors." Staff monitoring will be initiated for 1 week following a staff abuse/neglect allegation, and then twice weekly for one month to monitor the staff member for further Abuse/Neglect events. 3. On or before 2/4/2022, the DON will educate all nursing, housekeeping, laundry, social services, and activities staff on Resident #19's updated care plan interventions. On or before 2/4/2022, the DON will also educate all nursing, housekeeping, laundry, social services, and activities staff on Abuse/Neglect and Residents Rights. 4. An audit will be initiated to review the care plans and behavior monitoring on residents' TAR's who exhibit sexual behaviors. This audit will be conducted to ensure proper monitoring has been documented, and appropriate care plan interventions have been initiated for these residents 3 times per week Monday through Friday for 4 weeks and then once weekly for 2 months or as deemed necessary by the QAPI team. An audit will be initiated to monitor staff members who have substantiated allegations made against them regarding Abuse/Neglect. This audit will be conducted for one week	

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F 600	Continued From page 6 incident was a misunderstanding. Staff member A stated staff member I did not mean for it to be abusive, but she did use foul language. Staff member A stated he did not directly monitor staff member I after the incident. Staff member A stated he kept an eye on staff member I but did not want the staff member to know he was watching her because she wouldn't be abusive if she knew he was watching. Staff member A stated he did not record any monitoring of staff member I after the incident occurred. Review of the Facility Reported Incident, submitted on 10/6/21, showed "Upon investigation and interview with staff and residents, verbal abuse is substantiated. ...[Staff member I] was suspended and will be reeducated on Abuse/Neglect and resident's rights prior to working another shift..." The facility did not monitor staff member I. Review of the facility's policy titled "Abuse Prevention Plan - Montana Policy," with a revision date of March 2019, showed, "...1. Verbal Abuse the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability..." 2. During an interview on 1/20/22 at 7:50 a.m., staff member D stated she had cared for resident #s 19, 25, and 26. Staff member D stated she had been working on 6/16/21, when a staff member reported she overheard resident #19 make sexually inappropriate statements after approaching resident #25 in the dining room.	F 600	following the return of the staff member after suspension, and then twice weekly for one month or as deemed necessary by the QAPI team. 5. The results of these audits will be shared with the QAPI team on 2/10/2022. Further action will be completed as deemed necessary by the QAPI team. 6. Compliance will be met by 2/10/2022	

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F 600	Continued From page 7	F 600		

Staff member D stated the facility was aware of resident #19's history of sexually inappropriate behaviors but had not been able to identify any specific triggers.

Review of the investigative documents for the incident which occurred on 6/16/21, showed the inappropriate sexual statement did occur and, "[Resident #19] has the cognitive ability but chooses not to remember that inappropriate verbal or physical interactions are not appropriate."

Review of resident #19's Incident SBAR note, dated 6/16/21, showed the staff member had observed resident #19 sitting at a table with female residents and overheard him say, "he would play with her boobies and belly all he wanted." The note showed resident #19 was immediately redirected to his own table.

Review of resident #25's Incident SBAR note, dated 6/16/21, showed she was sitting at her assigned table in the dining room when resident #19 rolled himself to her table. The note showed resident #25 told resident #19 to go back to his own table, and told her tablemate resident #19, "... was a dirty old man."

3. Review of resident #19's Behavior Progress note, dated 11/10/21, showed resident #19 was found in his wheelchair in a female resident's room across the hall from his room. The note showed, "... [resident #19] with his left hand under [resident #26's] shirt and groping her chest." The note showed when resident #19 was asked what he was doing, he replied, "Let's go, these women are pretty tired this morning and I'm not getting much out of them." Resident #19 was taken back

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F 600	Continued From page 8	F 600		

to his own room.

Review of the investigative documents for the incident which occurred on 11/10/21, showed resident #19 was found in resident #26's room touching her inappropriately. The documents also showed resident #19 was moved to a room away from other residents and staff continued to monitor him for behaviors and redirected as needed.

During an interview on 1/20/22 at 11:46 a.m., staff member E witnessed resident #19's sexually inappropriate behavior of making sexual statements and touching female residents, including resident #26 who lived across the hall. Resident #19 displayed the same inappropriate sexual behavior toward female staff. Staff member E stated the CNAs had to watch resident #19 when he was out of his room and redirect him when these behaviors had occurred. Staff member E stated she was unaware of any identified triggers and had found setting boundaries with resident #19 had helped to decrease his inappropriate sexual behaviors when she provided care to him.

Review of resident #26's IDT note, dated 11/10/21, showed, "Resident to resident physical sexual contact: ... continue to advocate for resident due to her altered cognition and vulnerable status."

Review of resident #19's Care Plan, date initiated 10/2/17, showed a focus of sexual disinhibition related to alcohol and psychosis. The care plan showed interventions of monitoring behaviors, intervening to prevent inappropriate interactions with other residents, and reminding resident

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F 600	Continued From page 9 frequently he is not to touch any resident. The care plan failed to show any interventions related to setting boundaries as a way to minimize his inappropriate secual behaviors. Review of resident #19's TARs, dated from 6/21 through 1/22, showed behavior monitoring for a variety of behaviors, including itching, picking at skin, agitation, hitting, and aggression. The TARs failed to show any sexual behaviors were being monitored. Review of the facility's policy titled, "Abuse Prevention Plan - Montana Policy," dated March of 2019, showed, "... all residents residing in the facility will be protected from abuse, ... and that interventions are implemented to provide the vulnerable adult with a safe living environment." The policy showed, "... a vulnerable adult means any resident receiving services from this facility who may be unable to report maltreatment without assistance due to physical or mental impairment."	F 600		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		2/10/22

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F 880	Continued From page 10	F 880		

a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 880	Continued From page 11 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect residents from transmission of COVID-19 during a resident outbreak by not maintaining six-foot social distancing and not offering masks for the residents during meal service. This deficient practice had the potential to affect all residents at the facility. Findings include: During an interview on 1/20/22 at 8:00 a.m., staff member B stated the facility was in outbreak status, due to four residents testing positive for COVID-19 on 1/19/22. Staff member B stated the facility moved the residents that tested positive to a quarantine unit. Staff member B stated the facility was going to start testing residents and staff members every day. Staff member B stated the facility was going to continue with communal dining because the four residents who tested positive had been placed in quarantine. Two residents that tested positive were in the Eagle Cliff dining room for dinner service the night before.	F 880	DIRECTED PLAN OF CORRECTION This Directed Plan of Correction is required by the Centers for Medicare and Medicaid, and the Montana State Office of Inspector General, Certification Bureau, related to the identification of deficient practice for F880 - Infection Control, cited at the Severity and Scope of F. Corrections are to be completed by the date noted in Criteria Five - the Date of Completion/Compliance (X5 date). At a minimum, the facility will carry out and complete the following plan: 1. Criteria One: Corrections a. Member(s) of the governing body will review the Form CMS-2567 and determine why the facility administrative team failed to take timely action related to the implementation of interventions for infection control prevention for the spread of Covid-19, when residents who had	

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	275123	A. BUILDING _____ B. WING _____	C 01/20/2022

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F 880	Continued From page 12 During an observation on 1/20/22 at 8:15 a.m., communal dining was occurring in both dining areas. Residents were not seated six feet apart and were not wearing masks. During an interview on 1/20/22 at 10:19 a.m., staff member B stated the residents did not want to wear masks, and the facility tried to keep them six feet apart while dining, but the residents would still congregate together. Staff member B stated she had a phone call with corporate and was told to suspend all communal dining due to the COVID-19 outbreak. Record review of facility infection control policy and procedures did not address communal dining and mask use during a resident COVID-19 outbreak.	F 880	participated in communal dining were found to be positive for Covid-19, and also why the facility had not previously upheld infection control measures of social distancing or mask use for the residents during dining, as needed. This failure put others at risk for transmission of the virus. The governing body member(s) will determine what education will be necessary and carried out for facility administration/management, in an attempt to prevent future non-compliance. Education for the administrative staff on infection control measures related to interventions and prevention of Covid-19, and policy/procedure expectations, will be completed by a designee who does not work at the facility, and this education will be necessary for the determination of compliance. b. The facility administrative team will review/assess the deficient practices identified on the Form CMS-2567 for the failures of not protecting residents from transmission of COVID-19 during a resident outbreak, and failed to maintain six-foot social distancing and offer masks during resident meals, as needed. The facility was aware of the Covid-19 positive resident(s), and did not take action on measures for protecting other residents in social settings, such as the dining room, until facility administration was directed to. The intent of the review will be to determine contributing factors for why immediate and timely interventions were not implemented at the facility level, and by facility staff, for the prevention of the	

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spread of Covid-19, and then plan and implement corrective measures for the concerns identified.

2. Criteria Two: Identification of Others

Facility administration and a member(s) of the governing body will determine if residents were negatively affected by the deficient practices identified, and ensure evidence of the determination and method used is documented. If negative outcomes were identified the facility will ensure corrections and interventions are implemented for those residents as related to infection control and Covid-19.

3. Criteria Three: Systems

a. Member(s) of the governing body will review the Form CMS-2567 and determine why the facility administrative team failed to take timely action related to the implementation of interventions for infection control prevention for the spread of Covid-19, when residents who had participated in communal dining were found to be positive for Covid-19, and also why the facility had not previously upheld infection control measures of social distancing or mask use for the residents during dining, as needed. This failure put others at risk for transmission of the virus. The governing body member(s) will determine what education will be necessary and carried out for facility administration/management, in an attempt to prevent future non-compliance. Education for the administrative staff on

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F 880	Continued From page 14	F 880	infection control measures related to interventions and prevention of Covid-19, and policy/procedure expectations, will be completed by a designee who does not work at the facility, and this education will be necessary for the determination of compliance. b. The facility administrative team will review/assess the deficient practices identified on the Form CMS-2567 for the failures of not protecting residents from transmission of COVID-19 during a resident outbreak, and failed to maintain six-foot social distancing and offer masks during resident meals, as needed. The facility was aware of the Covid-19 positive resident(s), and did not take action on measures for protecting other residents in social settings, such as the dining room, until facility administration was directed to. The intent of the review will be to determine contributing factors for why immediate and timely interventions were not implemented at the facility level, and by facility staff, for the prevention of the spread of Covid-19, and then plan and implement corrective measures for the concerns identified. c. The facility will provide education to staff for infection control measures related to communal dining, social distancing, and mask use. The facility will identify which classifications of staff will need to receive this education, and it should include at a minimum, any staff who will, or who has the potential to, participate in communal activities. To show return	

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demonstration of the education provided, the facility will observe staff and residents during meals daily, each day of the week, and this will include each dining room and each meal session at least one time a week. During these observations, monitoring of infection control practices will occur and on the spot education will be provided to staff or residents if deficient practices occur. Documentation of education provided, either in a group session or individually on the spot when monitoring is occurring, will be documented to show actions taken.

d. The DON/Nursing Administrative team will develop an internal departmental monitoring system which will be ongoing after the date of completion (X5) as related to infection control practices for the failures identified. This system will follow the facility policy and procedure expectations, and include onsite visual observations for infection control prevention in group settings, such as dining. Concerns identified during monitoring, will be addressed timely by nursing and sent to QAPI for review/discussion.

Criteria Four: Monitoring

a. The DON/Nursing Administrative team will develop an internal departmental monitoring system which will be ongoing after the date of completion (X5) as related to infection control practices for the failures identified. This system will follow the facility policy and procedure

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F 880	Continued From page 16	F 880	expectations, and include onsite visual observations for infection control prevention in group settings, such as dining. Concerns identified during monitoring, will be addressed timely by nursing and sent to QAPI for review/discussion. b. The QAPI committee will review the Form CMS-2567 and actions taken by the facility to ensure all quality deficient practices for this deficiency are addressed timely and thoroughly. The QAPI committee will meet bi-weekly for 2 months, and then monthly for 2 months, for the review, discussion, or needed action, as related to the deficient practices identified in this deficiency, as to address ongoing concerns if they occur. c. The QAPI committee will review all corrections completed for F880, on or prior to 2/15/22, to determine if compliance has been achieved for F880 - Infection Control. This determination will be documented in a manner in which the State Survey Agency may obtain evidence of this decision, and the evidence/documentation will be provided to the surveyor during the revisit survey. Criteria Five: Date of Completion/Compliance - 1/16/2022	