STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275093	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Community Nursing Home	107 6th Ave S W Ronan, MT 59864

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400 Based on observation, interview, and record review, the facility failed to protect a resident's right to privacy of their body for 1 (#8); and failed to have a process for evaluation and re-evaluation , or a policy, for video cameras and the continued use and impacts on personal privacy for 1 (#84) of 4 residents sampled for continuous video monitoring. Findings include: 1. During an observation on 3/12/24 at 9:19 a.m., there were four video monitors at the front nurses' desk. The monitors were positioned so nursing staff could see them while at the computers, however the content on the screen could also be viewed by anyone standing at the periphery of the nurses' station. Resident #8 was observed on the camera by the surveyor to be placed in bed by two staff members and undressed from the waist down for incontinence care. The camera in the resident's room was not turned, and the entire care procedure could be viewed by anyone at the desk or on the periphery. During an interview on 3/12/24 at 9:25 a.m., staff member K stated they [nursing and aides] usually turn the camera in the resident's room for privacy and it had gotten missed. During an interview on 3/13/24 at 9:40 a.m.,staff member B stated the facility did not have a policy on the use of video monitoring for residents, but the expectation was cameras would be turned away during cares. Staff member B stated [staff member J] had said anything viewed behind the nurses' station was covered by HIPAA. 2. During an interview on 3/11/24 at 3:52 p.m., resident #84 stated she had a camera in her room and an alarm on her door because she had fallen several times. She stated if she could get stronger and stop falling she would be able to have the monitors removed. Review of resident #84's nursing progress notes dated 8/2023 - 3/2024, showed the resident continued to have eight falls while on the 24-hour video monitoring intervention. Review of resident #84's consents for 24-hour continuous video monitoring, dated, 8/11/23 and 12/29/23, signed by her representative, showed there would be a reevaluation of the monitor use in three months. There was no documentation of the reevaluation. Review of resident #84's Significant Change MDS, dated [DATE], showed the resident had a BIMS of 15; intact cognition. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #84's nursing progress notes, dated 8/11/23, showed the resident was unhappy about the video monitoring and felt like she was in prison. During an interview on 3/13/24 at 9:40 a.m., staff member B stated the facility did not have a policy on their use of video monitoring. There were no written protocols determining: - Criteria for the residents being placed on 24-hour monitoring, - Physician orders, - Re-evaluation of the 24 hour monitoring as an intervention, or - Privacy procedures for staff during care. During an interview on 3/13/24 at 1:55 p.m., staff member A stated the facility tried to use the video monitoring as a last resort for resident fall prevention.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 50245 Based on observation and resident interview, the facility failed to provide an emergency call light system for 2 (#s 10 & 27) of 2 residents sampled for call light concerns. Findings include: During an interview on 3/12/24 at 5:22 p.m., resident #27 stated his call light did not work for quite a while when another piece of equipment had been used to allow for more than two call lights to be plugged into the wall. Resident #27 also stated, People would not really believe me (when I said) that it did not work. He also said that he now pays close attention to the call light system as there have been instances where a staff member has clipped the call light to the overhead light, clipped it to the curtain, or accidentally pulled the cord out of the wall when moving the curtain. Resident #27 mentioned these instances were all by accident, but still made it difficult for him to access the call light or get help when he needed it. During an observation on 3/12/24 at 5:22 p.m., the call light splitter did not work in the resident's room; therefore, the call light was not working for resident #27. During an interview on 3/13/24 at 1:36 p.m., a chair alarm had been going off in resident #10's room for several minutes. Resident #10 had self-transferred from her wheelchair to her chair. Resident #10 stated the call light system had not been working for about two to three days. She also stated, It is the worst at night so sometimes I just yell. Resident #10 did say they (staff) were putting in a work order for the call light (to be repaired) at this time. During an observation on 3/13/24 at 1:36 p.m., neither the bed or chair call lights worked in resident #10's room. Observation showed two different call light cords. One call light was clipped to resident #10's bed while the other call light was clipped to the chair. Record review of the facility's policy and procedure on Call Lights, dated 6/2/20, showed, If call light is defective, report immediately to office so that they can have Maintenance repair it. Check room frequently until light is repaired.