

CORE ISSUES

Facility	License #	Physical Address	Phone Number
Great Falls Plaza dba Golden Eagle Plaza	13369	1615 9th St. S.	406-268-0100
Administrator	City	Zip Code	Survey Date
JUDY LINDQUIST	Great Falls	59405	08/03/2017
Survey Team Leader	Survey Type		Response Due
Wooten, Tara	Complaint Inspection		08/13/2017

Item #	Rule ()	Description
1	37.106.2843-3 PERSONAL CARE SERVICES	<p>Review of Resident #1 file.</p> <p>In the review of Resident #1's file, an incident report (IR) was found for a fall on 4/21/2017 at 10:00p.m. and another IR was found for a fall on 4/22/2107 at 1:58a.m. The staff statement on the IR for the fall that occurred on 4/22/2017 stated: "Resident pulled call light. Found laying on floor near bed. She stated was getting up to use restroom, fell, hit head. Assessed carpet burn on left front calf and bleeding top of head. Assisted with gait belt to restroom by sitting on walker. Cleaned wound, and placed disinfectant on them. Head looked like 5-6 inch gash but after cleaning a small 1/2 – 1/4 in gash. C/o only just headache. Given Ativan 1:58am. With gait belt placed back into bed.</p> <p>Later she called and check saw blue large marking on right side of forehead, large swelling to nose. Placed cold compact on forehead. Client unable hold herself. Contacted Hospice nurse Stacy. She came to check client. Nurse contacted MD. Client sent out OOB. Ativan given 4:48am before she left and she pushed at least twice pain pack."</p>

		<p>The incident report indicates “Hospice Nurse Stacy notified MD” at 6:20a.m. and “Hospice notified” at 5:40 the resident family.</p> <p>When the resident fell at 1:58a.m. with noted injuries – ie., rug burn, laceration to the head, complaint of pain – the facility failed to notify the resident practitioner or family, and seek treatment for injuries in a timely manner.</p>
2	37.106.2849-2 MEDICATIONS: RECORDS AND DOCUMENTATION	<p>Review of Resident #1 file, Medication Administration Record (MAR).</p> <p>In review of Resident #1 file, it was noted she had the following allergies: Codeine Sulfate, Morphine Sulfate, NSAIDS, Azithromycin. In Resident #1’s file were 2 different log records for Codeine/Guaisfenesin – one for a 15ml bottle, and one for 120mls. A progress note, dated 4/21/2017 states: “1300pm Entry for 4/20/17 – evening – 2 bottles of Codeine/Guaifen found in residents’ room after she requested something for cough and informed this RN that she had the 2 bottles in her fridge. One bottle is full and one bottle had approximately 15ml remaining. Hospice RN assisted resident with giving her 5ml (1tsp) @ about 1630pm as we could not do so without an order. Hospice nurse stated she would get us an order to use the cough syrup. Resident was informed that if she needed any during the night the MA could bring it to her but not assist with pouring it from bottle – the resident would have to do this. The cup was marked with black line to indicate where one teaspoon was. Per report to this nurse – NOC MA had to take the medication to resident who then took the remaining 2 teaspoons (dose was for 1-2 tsp) q 6 hours PRN. We expect to see an order for the med today sometime.” On the narcotic log record, facility staff documentation indicates the medication was given multiple times between 4/20/17 and 4/21/2017. The last documentation of administration on the narcotic record is 10p.m. 4/21/2017.</p>

		Review of printed the MAR in resident file, facility e-MAR, and resident file showed no of an order for the Codeine/Guaisfenesin.
3	37.106.2849-4 MEDICATIONS: RECORDS AND DOCUMENTATION	Review of Resident #1 file. No order was found in the residents file for the resident to keep medication in her room and be fully responsible for taking the medication in the correct dosage and at the proper time.