STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275156	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwest Montana Veterans Home	65 Veterans Circle Butte, MT 59701

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure psychotropic medications were used to treat a residents' specific, diagnosed, and documented condition for 2 (#s 14 & 36); and failed to obtain a GDR signed by the prescribing doctor for five psychotropic medications for 1 (#23) of 13 sampled residents. This deficient practice failed to ensure the medication dosages were either clinically appropriate or a potential dose reduction was clinically contraindicated for the resident. Findings include: 1. Review of resident #14's original medication order, dated 4/1/25, showed Quetiapine Fumarate 200 mg, Give 1 tablet by mouth one time a day for Mental disorder. [sic] Review of resident #14's updated medication order, dated 4/2/25, showed Quetiapine Fumarate 200 mg, Give 1 tablet by mouth one time a day for bipolar depression. During an interview on 6/18/25 at 3:39 p.m., staff member M stated the resident's bipolar diagnosis was related to his Seroquel [Quetiapine Fumarate] medication order. During an interview on 6/18/25 at 3:52 p.m., staff member L stated they were sure the bipolar diagnosis was somewhere in the resident's past medical history and would have to go through all of the records, but getting records from the [Facility Name] could be challenging. Review of resident #14's H&P, requested 6/18/25, failed to show a past medical history diagnosis of bipolar disorder. During an interview on 6/19/25 at 8:26 a.m., staff member A stated they had done an ad hoc QAPI on their processes and spoke with the provider regarding resident diagnoses and medications. Review of resident #14's nursing progress notes, dated 6/18/25, showed the IDT had met and discussed the resident's diagnoses and relevant DSM-5 criteria for symptoms in relation to his medications and mental health treatment. The resident's diagnoses, medications, and PASRR were updated. 2. Review of resident #36's original medication order, dated 11/15/24, showed Risperdal 0.5 mg, One time a day for dementia and anxiety. Review of resident #36's updated medication order, dated 1/9/25, showed Risperdal 0.5 mg, One time a day for bi-polar disorder. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #36's consent for use of psychoactive medication therapy form, dated 11/15/24, showed the indication for use as dementia/anxiety. Review of resident #36's H&P, requested 6/18/25, failed to show a past medical history diagnosis of bipolar disorder. During an interview on 6/18/25 at 3:39 p.m., staff member M stated the resident's bipolar diagnosis was related to her medication order. Review of resident #36's nursing progress notes, dated 6/18/25, showed the IDT had met and discussed the resident's diagnoses and relevant DSM-5 criteria for symptoms in relation to her medications and mental health treatment. The resident's diagnoses, medications, and PASRR were updated. 3. During an interview on 6/18/25 at 3:48 p.m., staff member I stated resident #23 had been on psychotropic medications for a long time, and if the medications were listed on the MAR, then she gives them. Staff member I stated nurses were not involved when, or if, medications get reviewed for possible dose reductions. During an interview on 6/18/25 at 3:58 p.m., staff member C stated the pharmacist monitored when GDRs were needed and would make recommendations to the doctor for needed changes. Review of a facility document used for GDRs, titled, Consultant Pharmacist Recommendations to Prescriber, page 2 of 14, signed by staff member E, with date of 11/5/24, unsigned by the Physician/Prescriber, reflected the following: .The resident has been taking the following medication without a GDR. Clozapine 250 mg Taking 1 tablet at bedtime since 10/2021 Clonazepam 1 mg Taking 1 tablet at bedtime since 11/2021 Escitalopram 10 mg Taking 1 tablet once daily since 10/2021 Trazodone 50 mg Taking 1 tablet once daily since 7/2022 Hydroxyzine 25 mg Taking 1 tablet three times daily since 3/2022 .Physician/Prescriber Response: Agree, Disagree, or Other [All three boxes left blank/unmarked]. There was no physician signature or date. During an interview on 6/18/25 at 4:17 p.m., staff member G stated GDRs recommended by staff member E were reviewed and discussed monthly with the prescribing doctor. Staff member G stated the GDRs were not done electronically, and stated he would look for resident #23's signed GDR. Staff member G returned with one piece of paper, with no title, and it was a blank page, with page 15 of 15 in header, and a signature at the top of the blank page by staff member D. Review of a facility document titled, Tapering Medications and Gradual Drug Dose Reduction, Copyright 2021, [company name] (Revised April 2007), reflected the following: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Residents who use antipsychotic drugs shall receive gradual dose reductions . .the facility shall attempt a GDR at least annually .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure a PASRR Level II was completed for 1 (#32), and failed to ensure the residents' mental health diagnoses, for which they received psychotropic medication, were included on the PASRR for 2 (#s 14 & 36) of 13 sampled residents. Findings include: 1. Review of resident #14's PASRR, dated 4/1/25, showed the diagnoses of: chronic respiratory failure, unspecified mental disorder, post-traumatic stress disorder, and depression unspecified. Bipolar disorder was not listed. Review of resident #14's medication order, dated 4/2/25, showed Quetiapine Fumarate 200 mg, give 1 tablet by mouth one time a day for bipolar depression. 2. Review of resident #36's PASRR, dated 10/30/24, showed the diagnoses of: depression unspecified, cognitive communication deficit, fracture, and unspecified lack of coordination. Bipolar disorder was not listed. Review of resident #36's medication order, dated 1/9/25, showed Risperdal 0.5 mg, one time a day for bi-polar disorder. During an interview on 6/19/25 at 8:26 a.m., staff member A stated they had resubmitted PASRRs for both resident #14 and #36 after evaluating their diagnoses and mental health services with the provider. 3. Review of resident #32's Level I PASRR was completed on 1/10/25. Review of resident #32's EHR showed a medical diagnosis of Major Depressive Disorder on 2/25/25. Review of resident #32's EHR showed a Level II PASRR was not completed after resident #32's Major Depressive Disorder diagnosis. The information was requested 6/17/25 at 2:52 p.m. During an interview on 6/18/25 at 3:28 p.m., staff member B stated the facility had reached out to [entity name] after the diagnosis had been made, and [entity name] had told the facility no Level II PASRR was needed. Staff member B stated this conversation had not been documented. Staff member B stated after the mental health diagnosis was made, the facility should have resubmitted a Level I PASRR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure there was an updated care plan pertaining to trauma informed care for 1 (#32) of 13 sampled residents. The resident had ongoing nightmares and unpleasant memories, and he did not like talking about his time in the war, so he kept to himself. Findings include: Review of resident #32's Care Plan, with a revision date of 3/27/25, showed: Special Instructions . Trauma Triggers: Loud noises/events potentially increase risk of emotional lability and anxiousness. Interventions: Encourage/assist in establishing and maintaining normal/baseline routines and introduce any necessary change through communication and knowledge with (#32). Assist in noise reduction as possible. The care plan did not specifically address (with a focus, goal, and intervention) resident #32's PTSD or trauma concerning his time in the Vietnam War other than the special instructions shown above. During an interview on 6/16/25 at 2:03 p.m., resident #32 stated he currently had nightmares and many unpleasant memories from his past about the Vietnam War. He stated he had been a prisoner of war for eight years and had escaped twice during that time. During an interview on 6/18/25 at 4:15 p.m., resident #32 stated he did not like to talk with the other residents as they had always brought up the war, and this brought back tough memories for him. Resident #32 stated this was why he often liked to be in his room alone, and he did not participate in group activities. Review of a facility document, titled Care Planning - Interdisciplinary Team, not dated, showed: Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure ADL oral care was offered and performed for 1 (#30) resident out of 13 sampled residents. The resident was dependent on the help of staff, and he had noticeable halitosis when conversing, due to the lack of oral care. Findings include: During an observation and interview on 6/16/25 at 1:52 p.m., resident #30 stated staff would sometimes help him with brushing his teeth. During close interactions, there was a noticeable unpleasant odor to resident #30's breath. Resident #30 stated he did not have any dental problems or pain in his mouth. During an interview on 6/17/25 at 10:48 a.m., resident #30's breath had an unpleasant odor when this surveyor leaned in close to the resident. Resident #30 stated he had brushed his teeth himself that morning. During an interview on 6/18/25 at 11:35 a.m., staff member N stated resident #30 was more dependent than some staff realized. Staff member N stated staff had to help get him dressed this morning because he had two shirts on. Staff member N stated they noticed resident #30's halitosis as well that day. Review of resident #30's EHR showed the task, Oral Hygiene, and resident #30 was documented to be independent 26 out of the past 30 days. Review of resident #30's EHR showed under the medical diagnoses, Need For Assistance With Personal Care, dated 3/4/25; and Cognitive Communication Deficit, dated 7/6/23.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to ensure prompt treatment of a urinary tract infection for 1 (#49) of 13 sampled residents which resulted in the infection being untreated for a week after symptoms started. Findings include: Review of resident #49's nursing progress notes, dated 6/2/25, showed he had an elevated temperature of 101 degrees Farenheit. The provider ordered a CBC and urine culture to be sent to the hospital. Review of resident #49's urine culture, with a final result dated 6/4/25, was positive for infection. The antibiotic susceptibilities showed three medications the bacteria was sensitive to and one to which it was resistant. Review of resident #49's Medication Administration Record, dated June 2025, showed the resident was not started on an antibiotic until 6/9/25, five days after his urine culture results were received, and one week after symptoms began. During an interview on 6/18/25 at 2:00 p.m., staff member C stated the urinalysis results were received on a Sunday, and the provider on call was unable to see the results in the EHR system, or get them faxed. Staff member C stated the resident's infection results fell through the cracks. They had since completed education with nursing to make sure results were promptly addressed and antibiotics were started without delay.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observations, interviews, and record review, the facility failed to obtain physician orders, informed consents, signed statements of understandings, or develop a standardized process, including terminology, for the use of bed rails for 5 (#s 5, 23, 24, 33, and 41) of 13 sampled residents. Findings include: 1. During an observation on 6/16/25 at 11:10 a.m., bed rails were noted on both sides of resident #5's bed. Review of the Care Plan Report for resident #5, with an initiation date of 4/21/24, showed: Bed canes to enable bed mobility. Review of the resident #5's electronic medical record did not show physician orders or consents for bed rails. 2. During an observation on 6/16/25 at 10:27 a.m., bed rails were noted on both sides of resident #23's bed. Review of the Care Plan Report for resident #23, with an initiation date of 3/2/22, showed: Assist rails to aid in repositioning. Review of the resident #23's electronic medical record did not show physician orders or consents for bed rails. 3. During an observation on 6/16/25 at 11:13 a.m., bed rails were noted on both sides of resident #24's bed. Review of the Care Plan Report for resident #24, with an initiation date of 7/29/21, showed: bilateral bed canes for improved independence for bed mobility/repositioning and cares. Review of the resident #24's electronic medical record did not show physician orders or consents for bed rails. 4. During an observation on 6/16/25 at 10:44 a.m., bed rails were noted on both sides of resident #33's bed. Review of the Care Plan Report for resident #33, with an initiation date of 5/15/25, showed: [Resident #33] to have bilateral quarter bed rails to facilitate bed mobility and transfers. Review of the resident #33's electronic medical record did not show physician orders or consents for bed rails. 5. During an observation on 6/16/25 at 11:07 a.m., bed rails were noted on both sides of resident #41's bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan Report for resident #41, with an initiation date of 4/18/25, showed: [Resident #41] to have bilateral quarter rails to facilitate bed positioning, bed mobility and transfers. Review of the resident #41's electronic medical record did not show physician orders or consents for bed rails. During an interview on 6/17/25 at 4:33 p.m., staff member J stated consents and orders were needed for side rails. During an interview on 6/17/25 at 4:39 p.m., staff member C stated orders were needed for bed rails, but she was not sure if consents were needed. During an interview and record review on 6/18/25 at 8:21 a.m., staff member F showed this surveyor a blank form titled, Restraints: Side Rail Utilization Assessment, and stated, staff member K fills out the side rail form for every resident that needs side rails. During an interview on 6/18/25 at 2:42 p.m., staff member K stated he had residents sign a paper consent when they received bed rails. Staff member K stated he could do a better job with getting signatures for consents. Staff member K stated, I put orders into PCC after I do the assessments. During an interview on 6/18/25 at 4:32 p.m., staff member G stated the facility did not use side rails or bed rails because they were considered a restraint. Staff member G stated the facility only used bed canes for repositioning. Staff member G stated bed canes were all one specific size and only installed at the very top of the beds near the resident's head, not on the side of the beds. Staff member G stated since the facility did not use bed rails, consents were not needed. During an interview on 6/19/25 at 7:38 a.m., staff member H stated she would call bed rails either partial bed rails or side canes. Staff member H stated the facility only used two different types of bed rails, and both were never installed high up at the top of the beds, only on the sides. Staff member H stated it was confusing because there were so many names the facility used for bed rails, but Regardless of what they are called, a physician order and consent was needed. During an interview on 6/19/25 at 8:03 a.m., staff member A stated she was aware of the issue with staff calling bed rails and bed canes different things, but a signed consent was necessary regardless of what they were called. Staff member A was not aware there were no physician orders, signed consents, or statements of understandings for resident #s 5, 23, 24, 33, and 41. Staff member A stated all staff were going to receive education on the bed cane process, including what they were to call them next week. Staff member A stated the facility would stop using the document titled, Restraints: Side Rail Utilization Assessments, physical therapy was currently using to assess residents' preferences for quarter or half side rails. Staff member A stated she was going to revamp the whole process, and start having all residents sign statements of understandings and consents moving forward. A request was made on 6/18/25 at 11:06 a.m., for signed orders, consents, and statements of understandings for the use of bed rails for resident #s 5, 23, 24, 33, and 41 from the facility. No additional documentation was provided by the end of the survey. Review of a facility document, titled, Restraints: Side Rail Utilization Assessment, dated 2000, preventing falls and injuries while reducing side rail use, reflected the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.What type of side rail does resident/legal surrogate prefer? (circle choices) Full, Half or Quarter; 1 rail or 2 rails. Has the resident/legal surrogate been informed about side rail risks and signed the statement of understanding? . Review of a facility document, titled, Proper Use of Side Rails, dated Qtr 3, 2022, showed the following: .Consent for side rails use will be obtained from the resident or legal representative, after presenting potential benefits and risks .

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on interview and record review, the facility failed to ensure 1 (#32) resident of 13 sampled residents had the appropriate treatment and services for PTSD to allow the resident to attain his highest practicable mental well-being. This had the potential to affect other residents with similar PTSD concerns who did not frequently verbalize their concerns. Findings include: Review of resident #32's EHR showed a medical diagnosis of PTSD. During an interview on 6/16/25 at 2:03 p.m., resident #32 stated he had been a prisoner of war for eight years during the Vietnam War, and he had escaped twice during his time. He described many memories of his past during this conversation. One instance when he had escaped, a bullet flew between his legs. He stated he had been captured again, told he would not escape, and was put in isolation from that point going forward. Resident #32 stated he had shot many people and stated he should have shot more. Resident #32 stated he often had nightmares currently, as well as in the past. He stated in the past he accidentally choked his wife while he was sleeping. He stated he recently asked his wife to stay the night at the facility, but he stated she refused, and she did not feel safe sleeping so close to him. He stated he had never seen a psychiatrist or psychologist about his PTSD. He stated he used to speak with a family member in the past about his struggles, and this family member had told him he should see someone (mental health professional) regarding the PTSD. Resident #32 stated he used to love dogs, but he has not had the love in his heart to have a dog since the war. Resident #32 was apprehensive about seeing a psychiatrist or psychologist, but stated he did not mind speaking about it on a one to one level. During an interview on 6/18/25 at 4:15 p.m., resident #32 answered the following questions to the facility's Trauma Assessment, and each response was assigned a numerical meaning, which is noted in the parentheses: - 1. Repeated, disturbing dreams of a stressful experience from the past? Resident #32 stated, 4 (quite a bit). - 2. Feeling very upset when something reminded you of a stressful experience from the past? Resident #32 stated, 5 (extremely). - 3. Avoided activities or situations because they reminded you of a stressful experience from the past? Resident #32 stated, 4 (quite a bit). Resident #32 also stated he did not like to participate with the other residents as they always wanted to talk about the war and it brought up old memories for resident #32. - 4. Feeling distant or cut off from other people? Resident #32 stated, 1 (not at all). - 5. Feeling irritable or having angry outbursts? Resident #32 stated, 2 (a little bit). (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 6. Difficulty Concentrating? Resident #32 stated, 4 (quite a bit). Review of the previous facility Trauma Assessments (3/26/24, 6/26/24, 7/11/24, 9/25/24, 1/10/25, 3/5/25) showed resident #32 did not answer any of these questions above a level 3, showing an increase in the frequency of some areas. Review of resident #32's Care Plan, with a revision date of 3/27/25, showed no area where PTSD or trauma was addressed with a focus, goal and interventions for staff to be able to utilize, or interventions to identify his triggers or ways to assist him if he was triggered. Review of a facility document, titled Trauma Informed Care, revised 12/2016, showed, It is the policy of our facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure contact precautions were followed for 1 (#13) of 13 sampled residents. This had the potential to result in the transmission of microorganisms from resident to resident. Findings include: During an observation on 6/16/25 at 11:20 a.m., staff member P transferred resident #13 from his wheelchair, to his recliner, in his room. Resident #13's door had two signs posted: Enhanced Barrier Precautions and Contact Precautions. Staff member P was not wearing a gown or gloves while transferring resident #13. Staff member P had walked into resident #13's bathroom to grab a washcloth for the resident's face, touching the bathroom door handle on the way. Staff member P also touched resident #13's water container. When staff member P was leaving resident #13's room, the staff member grabbed their backpack off of the floor, did hand hygiene with hand sanitizer, and left resident #13's room. During an observation on 6/16/25 at 11:32 a.m., staff member O walked into resident #13's room without donning a gown or gloves to get the resident for lunch. Staff member O stated they were unsure why the resident had been on contact precautions. During an interview on 6/16/25 at 11:39 a.m., staff member J stated they were unsure of the proper precautions at this time, but staff member C was coming to help assist with any additional questions. Shortly after, staff member C arrived, and staff member C stated resident #13 was on contact precautions because of an infection called Tinea (fungal infection), located on his arms. Staff member C stated the resident was supposed to wear sleeves at all times to prevent the spread of the disease, in addition to all staff wearing proper PPE, and following the infection control signage posted on the doors. Review of resident #13's physician order, started 5/13/25, showed, Contact Precautions: To prevent the spread of Tinea Cruris, also known as jock itch, it is essential to follow specific contact precautions. This fungal infection predominantly affects the skin in the groin area and can be highly contagious through direct skin-to-skin contact or by sharing personal items. Review of facility policy, titled Isolation - Categories of Transmission-Based Precautions, last revised 1/2012 showed: . implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275156	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwest Montana Veterans Home	65 Veterans Circle Butte, MT 59701

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure biohazardous waste was stored properly (i.e.: biohazardous waste bags properly stored in the boxes, sealed with a puncture-resistant lid to prevent the attraction of insects or animals). This had the potential to result in a spread of disease or contamination; or an accidental poke of a needle if handled or disposed of improperly. Findings include: During an interview on 6/18/25 at 2:50 p.m., staff member S stated they were unsure where the red biohazard bags were disposed of but stated the CNAs knew where to dispose of the materials at the end of the day. During an interview and observation on 6/18/25 at 3:00 p.m., staff member R showed the biohazardous waste was disposed of in a locked shed near the garage. Upon observation, there were approximately eight biohazard cardboard boxes stacked, two of which were still open and not full. There were approximately eight biohazard bags that were also stacked on top of one another in the back left corner of the shed and not located in a box. The entire biohazardous waste area had a unpleasant odor once the door had been opened. The shed did not contain an area where a staff member could use hand hygiene after disposing or handling the biohazardous waste. The shed containing the biohazardous waste was observed to be full and there were boxes towards the front of the shed. During an interview on 6/19/25 at 8:12 a.m., staff member Q stated they were unsure how often the company would come to pick up and dispose of the biohazardous waste. They stated they thought it was every month or every two months, but stated they would find out. Staff member Q stated the biohazardous waste was not secured or boxed every night to ensure the bags were not lying on the ground. Staff member Q stated they were responsible for ensuring the bags were placed in the boxes and stated they recently ran out of cardboard boxes, but an order was placed. Staff member Q stated when it rained the boxes in the front of the shed could get wet so they would try to ensure the boxes were far enough back to prevent this from happening. Review of the CDC recommendations showed Medical wastes requiring storage should be kept in labeled, leak-proof, puncture-resistant containers under conditions that minimize or prevent foul odors. The storage area should be well ventilated and be inaccessible to pests (Centers for Disease Control and Prevention, 2024). Review of a facility policy, titled Medical Waste Storage, revised 5/2012, showed: . 5. Medical wastes meeting this criteria will be maintained at the following location(s): picked up once a month or PRN . 6. Medical wastes must be stored so that it is protected from animals and does not provide a food source for insects or rodents. Review of a facility policy, titled Medical Waste - Preparing for Pickup, revised 5/2012, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275156	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Individuals cleaning up medical waste generated by this facility will place it in a container or combination of containers that are rigid and leak resistant, impervious to moisture, strong enough to prevent tearing or bursting under normal handling, and securely sealed. 3. Individuals who handle blood or body fluids will pour them into a container resistant to breaking and equipped with a tightly fitting lid or stopper. Review of a facility policy, titled Medical Waste Containers, revised 5/2012, showed: 1. Medical waste containers should be located throughout the facility and treatment areas must be kept covered at all times. Bibliography: Centers for Disease Control and Prevention. (2024, January 4). Regulated Medical Waste. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/infection-control/hcp/environmental-control/regulated-medical-waste.html