STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a facility policy and procedure for written grievances to be submitted anonymously; failed to provide residents with readily available grievance forms; and failed to provide a resident with the option to submit written grievances anonymously for 1 (#83) of 25 sampled residents. This deficient practice could affect all residents residing in the [NAME] cottage. Findings include:During an observation on 7/14/25 at 3:30 p.m., a walk-through of the [NAME] cottage common areas was conducted. A resident information board was located on a wall across from the entrance to the cottage. No documentation was observed on how a resident could file a grievance. No grievance forms were found readily available to residents, and no secure receptacle was identified to submit a written anonymous grievance.During an interview on 7/14/25 at 3:36 p.m., staff member K stated that if a resident had a grievance, the resident would notify a staff member. Staff member K stated that the staff member would then notify her, and she would address the issue with the resident and provide a grievance form to the resident if it was needed. Staff member K stated the resident grievance forms were stored in her office. Staff member K stated that resident grievance forms were not available to residents in the common areas of the [NAME] cottage. Staff member K stated the [NAME] cottage did not have a secure receptacle for residents to submit a written grievance anonymously.During an interview on 7/15/25 at 10:30 a.m., resident #83 stated the resident council meets monthly in the dining room. Resident #83 stated she did not know where grievance forms were located in the ([NAME]) cottage, or whether a grievance could be filed anonymously. Resident #83 stated that if she had a problem, she would let staff know, and they would take care of the issue. Resident #83 stated she was not sure how to submit a written grievance anonymously if she needed to.Review of the facility's policy titled GRIEVANCE POLICY, dated November 2016, showed: . PROCEDURE . E. A grievance or concern can be expressed orally to the Grievance Official or [facility staff] or in writing using a grievance form, which will be located adjacent to the Resident of Rights posting located throughout [facility name].F. Grievances may be given to any staff member who will forward the grievance to the Grievance Office, or they may file the grievances anonymously to the Compliance Hotline at [Phone Number]. [sic]

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
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 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 observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan, for a resident who required oxygen therapy for 1 (#12) of 25 sampled residents. The facility's failure could jeopardize the resident's health resulting in a risk for low blood oxygen levels or oxygen services not being provided. Findings include:During an observation on 7/16/25 at 10:36 a.m., resident #12 was in her room sitting in a recliner with her legs elevated. Resident #12 appeared to be asleep with a nasal cannula applied to her nostrils. Resident #12's oxygen concentrator was running at 2 liters per minute. During an interview on 7/17/25 at 9:37 a.m., staff member B stated the MDS nurse and interdisciplinary team were responsible for updating a resident's care plan. Staff member B stated he was not sure why resident #12's oxygen therapy was not initiated in the resident's care plan. Staff member B stated, I don't know why it is not there. Review of resident #12's medical provider order, dated 2/20/25 at 9:30 a.m., showed, Oxygen at 2 liters/minute. Keep oxygen saturation above 90% Delivery method nasal cannula [sic]Review of resident #12's current care plan, with a revision date of 3/21/25, did not include a focus, goal, or interventions related to resident #12's oxygen therapy treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure a resident-centered care plan was updated to include specific activity preferences and current participation for 2 (#s 24 and 56); and include use of enhanced barrier precautions for 1 with an indwelling urinary catheter (#9) of 25 sampled residents. This deficient practice increased the risk of staff members not implementing resident-centered care plans in the specific areas of activities and infection control. Findings include: 1. During an observation and interview, on 7/14/25 at 3:45 p.m., resident #32 was sitting in her recliner with her feet elevated, watching television. When asked, resident #32 stated she did participate in activities, but she was unable to identify which activities she participated in. Resident #32 was able to answer yes or no questions regarding participation in reading activities and watching television. The resident was unable to recite or recall the names of any activities on her own. NF1 arrived at 3:50 p.m. and joined the conversation regarding resident #32's care. NF1 stated he came almost daily to visit resident #32, and she did not participate in many of the group activities in the cottage. During an interview on 7/16/25 at 9:01 a.m., staff member O stated resident #32 did not routinely participate in group activities in the cottage, except for church on Friday. Staff member O stated that resident #32's family visited daily. Staff member O stated she talked to each resident and representative quarterly. Staff member O stated that notes about changes in the resident's activity participation and preferences were documented in the care team meeting progress notes. When asked where she was documenting the specific types of preferred activities for each resident, she stated it should have been on the resident's care plan. Review of resident #32's Activity Care Plan, dated 1/21/25, showed the problem's focus was that the resident was dependent on staff and family for meeting her social needs, which was due to cognitive deficits and physical limitations. The care plan showed interventions identified by the facility included encouraging ongoing family involvement and inviting the resident's family to special events, activities, and meals. The care plan failed to show the importance of church services, the resident's preference for not attending most group activities, or the use of one-to-one visits. 2. During continuous observations on 7/14/25 from 2:00 p.m. to 3:45 p.m. and 4:10 p.m. to 4:30 p.m., resident #56 did not come out of her room. The door to the resident’s room was closed, and the resident was left undisturbed. During an observation on 7/15/25 at 11:15 a.m., resident #56 requested help with a jacket and was escorted from her room to the dining room in the common area. The resident was not wearing her hearing aids, and staff used a small whiteboard to communicate with the resident. During an interview on 7/16/25 at 11:22 a.m., staff member H stated resident #56 was very hard of hearing and often did not participate in any activities in the cottage. Staff member H stated the resident liked visiting with family and listening to music, if she was located close enough to hear the music. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/17/25 at 9:04 a.m., staff member O stated she had not completed the activity assessment for resident #56 because the resident resided in a different cottage. Resident #56 was moved to the [NAME] Cottage on 3/3/25, and the first care team meeting was not completed until the middle of June 2025. Staff member O was not able to explain why the care team notes for activities were not completed during the care conference, when asked. Review of resident #56’s care team meeting notes, dated 6/24/25, showed the activities section was blank. Review of resident #56’s Activity Care Plan, dated 3/31/25, showed the problem's focus was the resident was dependent on staff for meeting her social needs due to cognitive deficits. The care plan interventions were to converse with the resident during care, encourage family involvement, ensure activities were compatible with the resident’s physical and mental capabilities, and compatible with the resident’s known interests and preferences. The care plan failed to reflect the resident’s interests and preferences, or the use of one-to-one visits to meet the needs of resident #56. 3. During an observation on 7/14/25 at 8:23 a.m., resident #9 was lying in her bed, and the resident had a urinary catheter. Resident #9 had enhanced barrier precaution signage on the front of the door, visible to anyone entering the resident's room. Resident #9’s room did not have personal protective equipment supplies available inside or outside of the room for staff to access and ensure enhanced barrier precautions were followed when providing resident care. During an interview on 7/17/25 at 9:51 a.m., staff member C stated she and staff member B updated resident care plans with nursing-related needs. Staff member C stated she would update the care plans for health conditions requiring the use of precautions. Staff member C stated nursing staff providing direct care in cottages typically did not enter updates on the resident care plans. Staff member C stated CNAs and nursing staff were able to view resident care plans. Staff member C stated it would be a good idea to include enhanced barrier precautions on a resident’s care plan. Staff member C stated she did not add enhanced barrier precautions related to resident #9’s indwelling urinary catheter to the care plan. Staff member C stated she would check to see why personal protective equipment was not available outside of resident #9’s room. Review of resident #9’s care plan, showed two problems related to an indwelling urinary catheter, initiated 10/7/24: “… [Resident #9] has an ADL self-care performance deficit r/t Parkinson's disease, presence of Foley catheter, and mild cognitive impairment. … [Resident #9] has an indwelling Foley catheter r/t neurogenic bladder. She has pulled it out multiple times since admission.” The two care plan problems listed for the indwelling urinary catheter did not include goals or interventions to address the use of enhanced barrier precautions for resident #9 during care provided by staff. Review of a facility document titled, “Baseline Care Plans,” initiated 1/2019, 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
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	“… 3. Care Plans must be updated every three months… Look at the problem and assess if it is still appropriate, has goal been met. If goal not met, change interventions or change the goal. Review interventions to see if they need to be changed.” [sic] Review of a facility document titled, “Enhanced Barrier Precautions Policy,” revised 3/2024, showed: “… Enhanced Barrier Precautions is intended for nursing homes to prevent the spread of novel or targeted Multi-Drug-Resistant Organisms (MDROs) when residents have an infection or colonization with an MDRO or if the resident has a wound or indwelling medical device, regardless of MDRO infection or colonization. … Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities.”

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent, for 2 (#s 35 and 77) of 25 sampled residents. The medication error rate was calculated as 5.41 percent, and the medication errors placed the residents at increased risk of negative outcomes. Findings include:During a medication administration observation and interview on 7/15/25, between 8:28 a.m. and 8:45 a.m., staff member N stated, “I got busy in the other cottage, and [resident #77] was already wheeled out to the dining room, so I will just wait until she finishes her breakfast and returns to her room to give her insulin. Staff member N administered resident #77's insulin dose at 8:42 a.m., after resident #77 completed her breakfast and returned to her room. Review of resident #77's physician order, dated 7/4/25, showed, “Humalog 100 unit/ml Kwikpen before meals and at bedtime .” During an observation and interview on 7/16/25 at 8:04 a.m., staff member J gave two 500 mg tablets of acetaminophen to resident #35, who had been eating breakfast. In the MAR, staff member J charted the acetaminophen as given under the medication pantoprazole (40 mg), closed the computer, and walked away from the computer. The medication, pantoprazole, was in red on the MAR, and it was scheduled to be given at 7:00 a.m. Staff member J stated they would administer the pantoprazole at that time, when asked about the incorrect documentation, and stated they would have found the error when the rest of the medications in resident #35's bin were given around 8:30 a.m. or 9:00 a.m. Staff member J stated the pantoprazole should have been given before resident #35 had eaten. Review of resident #35’s EHR showed a physician’s order: “pantoprazole … take 1 tablet by mouth every day at 0700 (indications for use: GERD).”

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to dispose of expired foods; failed to ensure dietary staff prepared and served food in a sanitary manner; and failed to properly test dish sanitization water used to sanitize dishes in the kitchen. This deficient practice had the potential to affect all residents served food in the LTC Cottages by increasing the risk of foodborne illnesses. Findings include: 1. During an observation and interview on 7/16/25 at 7:58 a.m., several items were observed to have expired and were still in use. Staff member E stated all items should be dated with an open date, and any expired items used past their use-by date should be discarded. Staff member E stated, “We use the Montana use-by date for milk.” Items observed to be expired were: [NAME] Cottage: -salted caramel coffee creamer, expired June 2025. -sweetened original coffee creamer, expired June 2025. -sliced cheese, in a Ziploc storage bag, with a date of 6/18. -sliced ham, in a Ziploc storage bag, which was open and not dated. -one gallon of milk, half used, which had an expiration date of 7/9, but it did not have an open date. Powers Cottage: -salted caramel coffee creamer, expired January 2025 -sweetened original coffee creamer expired May 2025, and -individual prune juice cups expired November 2024. [NAME] Cottage: -sweetened original coffee creamer expired February 2025. [NAME] Cottage: -two bags of open chips, neither was labeled with an open date. -sweetened original coffee creamer, expired May 2025, with no open date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-salted caramel coffee creamer, expired January 2025, with no open date. -individually wrapped fig newtons, expired May 2025. Main storage room: -three gallons of milk, with an expiration date of 7/9. -a case of individual cups of grape juice, expired February 2025. During an interview on 7/16/25 at 8:54 a.m., staff member E stated, “I don’t have policies for food storage and handling, but I will work on creating some.” 2. During an observation and interview on 7/16/25 at 7:58 a.m., staff member E stated she did not have dietary policies; she only told her staff to follow Serve Safe guidance. The three dish sinks in the kitchen of [NAME] Cottage were observed to be full of dish water, rinse water, and sanitizer water. Staff member E stated, “Ecolab handles all sanitizer units. They (Ecolab) come and check them once a month. I was told when Ecolab took over and installed these units that we would not have to do testing on our sanitizer. We do not have test strips in any of the cottages, and we don’t test any of the water used for sanitizing dishes.” Review of a facility document titled “[Facility name]: Food Safety Policy” with an initiation date of 11/2016 and no revision date, showed: “Food Safety Requirements-Use and Storage of Food and Beverage Brought in for Residents, Food Procurement: Policy: It is the policy of [Facility name] to provide safe and sanitary storage, handling, and consumption of all foods including those brought to resident by family and other visitors. … Objective of Policy: The objective/intent of this requirement is to ensure that [Facility name]: … 2. Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility’s food handling processes. … ii. … This education will include at a minimum: 1. Proper food handling to prevent foodborne illness. 2. Perishable food such as meat, poultry, fish, and dairy products must be frozen or refrigerated immediately after receipt. … 4. Proper labeling and dating of each item. 5. Leftover foods will be used within 3 days or discarded. …”

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff used appropriate hand hygiene after assisting residents; failed to ensure staff used appropriate hand hygiene while preparing ready-to-eat foods; and failed to ensure enhanced barrier precautions were followed for 1 (#4) of 25 sampled residents. This deficient practice increased the spread of bacteria and increased the risk of infections to residents in the facility. Findings include:1. During an observation on 7/15/25 at 11:04 a.m., staff member G brought a resident, via wheelchair, placed her at a dining table after rubbing her back when speaking to her, went to the kitchen and brought a cup of coffee to another resident seated at a separate table. Staff member G then went back to the kitchen and brought a cup of coffee to the first resident. This was done without performing hand hygiene between residents. During an observation on 7/16/25 at 8:30 a.m., staff member G washed her hands and then went to a dining table, seated herself between two residents, and began feeding both residents their meal. Staff member G would provide a bite of food for one resident and then provide a bite of food for the second resident. Staff member G assisted both residents throughout the meal without any hand hygiene being performed. During an observation on 7/16/25 at 8:40 a.m., staff member H, using her bare hands, rolled a sitting stool across the dining area and placed it at a table with three seated residents. Staff member H then seated herself on the stool and began assisting all three residents with their meal, rolling between residents. No hand hygiene was performed throughout the meal. During an interview on 7/16/25 at 9:55 a.m., Staff member D said the facility had a CNA, studying to be a nurse, assigned to complete hand hygiene audits. Staff member D said the facility's Resource Team was responsible for the audits on Enhanced Barrier Precautions (EBP). The facility was providing education on EBP and was working with education for staff, and the information was still a little murky for now. Staff member D said if an issue was noted by the individuals completing the audit, it was reported back to the Infection Preventionist (IP), and education would be provided. During an interview on 7/16/25 at 2:07 p.m., staff member G said she had been provided hand hygiene instruction sheets for education on hand hygiene. Staff member G said the resource team came through the cottage to observe the staff and check to see if the staff were washing their hands correctly. The staff were observed washing their hands with soap and water at the sink and monitored for the process and length of time the hands were washed. Staff member G said she was not provided specific education on when hand hygiene was to be performed when serving meals or when appropriate while wearing gloves. Review of a facility policy, Handwashing/hygiene Policy, with a revision date of 1/23, showed: .Hand hygiene is a general term that applies to handwashing, antiseptic hand wash and alcohol-based hand rub (ABHR). Process .5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water if hands are visibly soiled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.7. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol. 8. Hand hygiene is always the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace handwashing/hand hygiene. 2. During an observation on 7/14/25 at 4:02 p.m., resident #4 was observed sitting in a wheelchair in her room. A wound dressing was observed on resident #4's left foot. During an observation on 7/15/25 at 8:43 a.m., staff member P was observed assisting resident #4 out of bed. Staff member P was not wearing an isolation gown as she transferred resident #4 to the chair and to the bathroom. During an interview on 7/15/25 at 9:25 a.m., staff member P stated there were currently no residents in [NAME] cottage who required PPE for their care. During an interview on 7/15/25 at 11:30 a.m., staff member N stated resident #4 was on hospice, but the facility nursing staff changed the wound dressings daily, or as needed. During an interview on 7/16/25 at 2:12 p.m., staff member N stated, The only person right now in the cottage that should have enhanced barrier precautions would be one (unnamed) resident with a urinary catheter. Review of the facility policy titled, Enhanced Barrier Precautions with a revision date of 3/24, showed: . The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status . High-Contact Resident Care Activities include: • Dressing• Bathing/showering• Transferring• Providing hygiene• Changing linens• Changing briefs or assisting with toileting . 3. During an observation on 7/16/25 at 7:51 a.m., staff member F was wearing a glove on the left hand and holding a pan handle, while cooking something that resembled eggs, on the stove. Staff member F used the gloved hand and reached into a container with shredded cheese. Staff member F took the cheese and sprinkled it over the food in the frying pan. Staff member F then touched the lid on the cheese and reached into the refrigerator, grabbing a package which was placed on the counter. Staff member F then grabbed a soiled bowl and rinsed it off in the sink. Staff member F then removed the soiled glove from her hand and threw it away. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/17/25 at 9:11 a.m., staff member E stated, “Staff should wash their hands and use gloves whenever they are preparing ready-to-eat food. If they touch something besides the food while serving, they should remove gloves and wash their hands . and It is not ok to wear a glove and then touch the handle of a pan and then use the same gloved hand to reach into shredded cheese . and would then be contaminated.” Review of a facility document titled Hand Washing and Glove Use, undated, showed: “Policy: Guidelines for hand washing and glove use to promote safe and sanitary conditions throughout department. [sic] Procedure: Hand Washing Procedure: 1. Hand washing is a priority for infection control. 2. Hands must be washed prior to . working with different food substances, i.e. raw chicken to fresh fruit, following contact with any unsanitary surface i.e . Procedure: Gloves: 1. Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food. 2. When gloves are used, hand washing must occur per above procedure prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed, see above. Gloves may be used for one task only.