STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275025	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalispell Rehabilitation and Nursing LLC	171 Heritage Way Kalispell, MT 59901

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45447 Based on observation, interview, and record review, the facility failed to ensure the floors and rooms were clean for 10 (#s 1, 2, 3, 4, 6, 7, 9, 10, 12, and 15) of 14 sampled residents for a clean environment. This deficient practice caused resident #3 to feel discouraged and frustrated. Findings include: During an interview on 4/8/24 at 10:50 a.m., resident #10 stated CNAs left soiled diapers in residents rooms, and the floors were dirty most of the time. During an observation on 4/8/24 at 10:55 a.m., resident #s 2 and 7 had 3 food wrappers on their floor, with 2 of the wrappers under resident #7's bed. During an observation on 4/8/24 at 11:00 a.m., resident #4's floor had dirt-like looking clumps by the bathroom. During an observation on 4/8/24 at 11:10 a.m., the hallway outside of resident #9's room contained four, medium sized spots of dried coffee spills. During an interview on 4/8/24 at 1:57 p.m., staff members G and I stated housekeeping was short staffed, and floor cleaning often did not get done on the weekends or after 3:30 p.m., because there were no staff scheduled during those times. Staff member G stated resident rooms had to go two or three days without floor cleaning because there was no one on (working from the department) the weekend, and if a housekeeping staff member called off. Staff member G and I stated they were responsible for cleaning the bathrooms, floors, and emptying garbages, and tried to get to as many as they could every day. During an interview on 4/8/24 at 2:53 p.m., staff member D stated the facility struggled with housekeeping and floor cleaning due to housekeeping staffing. Staff member D stated she noticed some of the rooms in the B hall and the dining area, were areas that were not cleaned as often as they should have been. During an observation on 4/9/24 at 9:10 a.m., the hallway outside of resident #9's room contained the same four spots of dried coffee spills as the previous day's observation. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/9/24 at 9:12 a.m., the hallway outside of resident #s 6 and 12's rooms contained multiple spots of dried coffee spills. During an observation on 4/9/24 at 9:15 a.m., the E hall had multiple areas of dried liquid spots, varying in sizes, on the floor. During an observation on 4/9/24 at 9:19 a.m., the hallway in front of resident #15's room contained multiple dried spots of liquid on the floor. During an interview on 4/9/24 at 9:23 a.m., resident #1 stated she had been in the facility since 4/5/24 and had not seen anyone clean her room or change her bed sheets. Resident #1 stated she felt the floors should have been cleaned since she had been at the facility, and her bed sheets should have been changed after her shower on 4/8/24. During an interview on 4/9/24 at 10:00 a.m., staff member H stated she was trying to cover housekeeping duties on the weekends, and the main dining rooms were not getting cleaned due to no housekeeping staff at dinner time. Staff member H stated she was trying to hire more staff. During an interview on 4/9/24 at 11:50 a.m., staff member C stated, There were no housekeeping staff at the facility on Sunday (4/7/24), so the lunch room got pretty bad. During an observation and interview on 4/9/24 at 12:33 p.m., resident #3's room had crumbs and debris under her bed, and at the base of her t.v. stand, and a bed pad soiled with urine on the floor. Resident #3's right sink handle was loose, with a greenish/bluish substance at the base where the handle touched the sink, and the resident's clothes were piled on the base of her closet. There was also a food tray sitting on a bedside table at the foot of the resident's bed. Resident #3 stated the crumbs and the pad on the floor had been there for four or five days, the cold-water handle in her bathroom had been broken for months, the dirty clothes in her closet were piling up for over a week, and her bed was seldom made. Resident #3 stated the food tray was still there from breakfast that morning. Resident #3 stated she has complained about these issues before, and nothing ever came of it. Resident #3 stated, I feel like I would be better in the street with how dirty this place is. It is so frustrating and discouraging. It is just depressing to be in this room. Review of resident #3's Annual MDS, with an ARD of 1/12/24, showed the resident had a BIMS of 15, cognitively intact. Review of a Grievance Report Form from resident #3, dated 3/5/24, showed: Nature of Concern : -Garbage has not been emptied in 'at least 3 days.' -Floor has not been swept . Review of the facility's policy, Resident Environmental Quality, revised 11/2023, showed, It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

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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 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. 45447 Based on observation, interview, and record review, the facility failed to implement care planned fall interventions for 1 (#4) of 2 sampled residents for falls. Findings include: Review of resident #4's Care Plan showed the following interventions for the resident's risk for falls: - 2/5/24: Ensure that lighting is adequate, and lights are functioning, including night lights. - 2/5/24: Ensure that the clothing does not cause tripping; and that rubber soled, heeled shoes or non-skid slippers are worn. - 3/6/24: Provide a fall mat for safety as resident will often attempt getting up on her own. Due to dementia resident does not remember to use call light and/or ask for assistance. - 4/1/24: Non-slip strips to be added to floor in front of recliner. During an observation on 4/8/24 at 11:00 a.m., resident #4 was sitting on the floor at the side of her bed, yelling out for help. The floor was wet with urine and did not have non-skid stripping or a fall mat. Resident #4 did not have footwear on, her sheets were soaked with urine, and the light was dim. During an interview on 4/8/24 at 1:40 p.m., staff member M stated to prevent falls based on resident #4's care plan, resident #4 was to be wearing footwear, and there was no structured toileting plan. During an interview on 4/9/24 at 9:54 a.m., staff member B stated the MDS coordinator was responsible for updating the residents' care plans. Staff member B stated she did not know why the floor strips were not applied to resident #4's floor. Staff member B stated the fall mat was removed because the facility thought it could be a tripping hazard for resident #4. Staff member B stated the request for the floor strips was put in a week ago by staff member A. Review of the facility's policy, Care Plans, Comprehensive Person-Centered, revised 3/2022, showed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45447 Based on observation, interview, and record review, the facility failed to implement interventions to prevent a fall for 1 (#4) of 2 sampled residents for falls. Findings include: Review of a Facility Reported Incident, dated 3/16/24, showed resident #4 had a fall resulting in an acute distal clavicle fracture. Resident #4 was admitted to the facility as she had a prior history of falls at home. Review of the facility's fall log showed resident #4 had seven falls from 2/8/24-4/8/24. Review of resident #4's Progress Notes, dated 4/1/24, showed resident #4 had a fall on 4/1/24, resulting in a 4 cm laceration to the left side of her scalp, requiring staples. During an observation on 4/8/24 at 11:00 a.m., resident #4 was sitting on the floor on the side of her bed, with her knees bent up to her chin, barefoot, quietly yelling for help. The resident was not wearing a brief or bottoms. The floor was wet with urine, and resident #4's bedsheets were soaked with urine. The room's lighting was dim. The floor did not have non-skid strips or a fall mat. During an interview on 4/8/24 at 1:40 p.m., staff member M stated resident #4 was supposed to wear footwear, in addition to having her bed low and being close to the nurse's station, to prevent falls. Staff member M stated a CNA checked on resident #4 ten minutes prior to her fall late that morning. During an interview on 4/8/24 at 2:53 a.m., staff member D stated resident #4's fall interventions included having a fall mat by her bed and wearing grippy, non-skid socks. Staff member D stated the resident had been up late during the night, and was sleeping in, so was not dressed prior to the fall. During an interview on 4/9/24 at 9:54 a.m., staff member B stated resident #4's fall mat was removed prior to the resident's fall because it was thought to be a fall hazard. Staff member B stated she did not know why the non-skid strips were not installed, and that staff member A had asked maintenance to install them a week prior to the fall. During an interview on 4/9/24 at 10:10 a.m., staff member L stated he did not receive a request or a call to install non-skid floor strips for resident #4 after the resident's fall on 4/1/24. During an interview on 4/9/24 at 10:26 a.m., staff member K stated he never received a request to install floor strips for resident #4. During an observation and interview on 4/9/24 at 1:05 p.m., staff member A stated he had made the request by phone call to maintenance to install the floor strips for resident #4, and did not have paper documentation of the request. Staff member A showed the surveyor his cell phone's call log, showing he called staff member L on 4/1/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #4's MDS, with an ARD of 2/8/24, showed the resident had a BIMS of 6, showing the resident had severely impaired cognition. Review of resident #4's EMR showed the resident had a Morse Fall Scale score of 80.0 on 4/1/24, showing the resident had a high risk for falling. Review of resident #4's Care Plan showed the following interventions for the resident's risk for falls: - 2/5/24: Ensure that lighting is adequate, and lights are functioning, including night lights. - 2/5/24: Ensure that the clothing does not cause tripping; and that rubber soled, heeled shoes or non-skid slippers are worn. - 3/6/24: Provide a fall mat for safety as resident will often attempt getting up on her own. Due to dementia resident does not remember to use call light and/or ask for assistance. - 4/1/24: Non-slip strips to be added to floor in front of recliner.