

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Kalispell Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>46400</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide a clean environment in resident showers; and failed to exercise reasonable care of resident clothing and other personal resident items from loss or theft, and failed to utilize a grievance process to address lost/missing items, for 4 (#s 5, 33, 67 and 69) of 25 sampled residents. Findings include:</p> <p>1. During an interview on 1/15/25 at 9:55 a.m., staff member P stated the facility shower rooms needed a deep clean.</p> <p>During an observation on 1/15/25 at 1:11 p.m., the shower room outside of the memory care unit had a sign on the door showing, Lost/missing clothes kept in A & E shower room. Inside the shower room, in the shower stall, was a used wet washcloth on the floor and pooled dirt near the drain. In the second room was a rack full of clothes, and a tabletop overflowing with clothing. There was a sign posted to remind staff to clean and disinfect the shower stall between residents for infection control reasons.</p> <p>During an observation on 1/16/25 at 10:27 a.m., the shower room outside of the memory care unit had a malodorous smell, brown stains near the drain, and a dirty brief on the floor next to a full trash can. In the second room was a rack full of clothes, and a tabletop overflowing with clothing.</p> <p>2. During an interview on 1/14/25 at 9:39 a.m., resident #69 stated, A bunch of my clothes were missing, and he had informed staff of the missing items.</p> <p>During an interview on 1/14/25 at 10:25 a.m., NF1 stated resident #5's clothing seemed to disappear, even when she wrote his name on them.</p> <p>During an interview on 1/14/25 at 10:26 a.m., resident #33 stated she had brand new clothing, that had not been worn, go missing.</p> <p>During an interview on 1/14/25 at 10:45 a.m., staff member S said they found part of resident #33's missing clothing and stated, We are trying to get everything out because state (State Survey Agency) is here.</p> <p>(continued on next page)</p>

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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 1/14/25 at 1:13 p.m., a resident was telling staff member A that his beard trimmers had gone missing again. Staff member A stated they weren't that expensive. The resident stated it wasn't about that, but he was sick of buying them.</p> <p>During an observation on 1/15/24 at 8:58 a.m., a document titled Lost and Found was observed to the left of the laundry room door, it showed Hello! Have you lost any clothes within the last 60 days? Please fill out this sheet so laundry know what to look for so we can find it, Thank you!</p> <p>During an interview on 1/15/25 at 9:04 a.m., staff member C stated the top resident grievance was missing laundry. Staff member C stated the laundry room looked like a hoarder's house. Refer to F585 - Grievances for more information related to the lack of an affective grievance process.</p> <p>During an observation and interview on 1/15/25 at 1:05 p.m. staff member Q stated they worked with activities to return clothes that had piled up monthly. Staff member Q stated the label maker was currently in activities because of the influx of Christmas clothing. Staff member Q stated clothes were labeled with the label maker, written on with a Sharpie, or they requested family to label the clothing.</p> <p>During an interview on 1/15/25 at 3:56 p.m., staff member C stated, I literally spend one third of my time looking for missing items.</p> <p>During an interview on 1/15/24 at 4:21 p.m., staff member A stated missing items are elevated to a grievance if they were aware of them. Staff member A stated when something doesn't get put on a grievance form they try to do a concern form for it, try to address the concern, and it doesn't always get in the grievance log. When asked about the current process for safeguarding personal items staff member A stated it is an expectation to complete an inventory of the resident's personal items and they try to complete an inventory listing on admission. Staff member A stated resident inventory is an area the facility could improve on.</p> <p>During an interview on 1/16/25 at 8:13 a.m., staff member J stated there were missing items all the time, more so clothing. Staff member J said the residents never had clothes, their closets were empty, and we never had anything to dress them in. When asked what happens if missing items were reported to her, she stated she goes to laundry or asks staff member I.</p> <p>During an interview on 1/16/25 at 8:30 a.m., staff member Q stated yes, we do have missing clothing, it definitely does happen. Staff member Q stated there was a no name cart or the clothing goes to the lost and found, and then it is gone through every once in a while. Staff member Q stated he believed there was also a lost and found area in c hall, because we had so many missing items.</p> <p>During an interview on 1/16/25 at 8:34 a.m., staff member R said there was a lot of missing clothing in the memory care unit, there were a lot of moving parts, and things can get lost quickly. When asked if there was a policy or procedure that was followed for missing items, staff member R stated she had not seen a policy</p> <p>During an interview on 1/16/25 at 9:13 a.m., NF5 stated resident #67 has discharged from the facility, and they were still missing an iPad, an apple watch, and clothing. NF5 stated she had requested resident #67's inventory sheet.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of resident #67's [Facility Name] Healthcare: Personal Belonging Inventory, showed resident #67's iPad and apple watch were present and inventoried.</p> <p>During an observation on 1/16/25 at 10:52 a.m., the resident council meeting agenda was posted on the bulletin board outside of the dining room. The meeting notes showed there was resident concern they were still missing clothing.</p> <p>51133</p> <p>A request was made for all communication related to lost and missing items for the last 30 days and nothing was provided as it related to resident #67's missing items.</p> <p>A request was made for the missing items policy, but nothing was received prior to the end of survey.</p> <p>A request was made for education provided to staff related to missing items and how to complete a resident's inventory. Review of the [Facility Name] In-service Attendance Sheet, Topic: Inventory Listing CNAs, complete upon admission, dated 10/9/24, showed 11 staff attended. A review of the staff list provided showed there are 116 staff, so 105 staff members were not listed on the in-service attendance sheet as being educated.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>51133</p> <p>Based on observation, interview, and record review ,the facility failed to maintain an affective grievance program to address resident concerns, specifically related to ongoing problems with lost resident belongings. This deficient practice increased the risk of a negative outcome for all residents who had concerns with grievances or lost items not elevated to a grievance level by management. Findings include:</p> <p>Review of a Grievance Report Form, dated 3/1/24, showed: Why do we fill out grievances? Nothing changes.</p> <p>Review of Grievance Report Form, dated 3/1/24, showed: Grievances not being addressed.</p> <p>During an interview on 1/15/25 at 3:56 p.m., staff member C said he was the grievance officer and stated the administrator and director of nursing determine what gets elevated to a grievance as it related to missing items.</p> <p>During an interview on 1/15/24 @ 4:21 p.m., Staff member A said social services handles the grievances, and the prior social worker was not very strong in her skillset. Staff member A said the grievance log for August 2024 was missing.</p> <p>During an interview on 1/15/24 at 4:21 p.m., staff member A stated missing items are elevated to a grievance if they were aware of them. Staff member A stated when something doesn't get put on a grievance form they try to do a concern form for it, try to address the concern, and it doesn't always get in the grievance log.</p> <p>During an interview on 1/16/25 at 9:13 a.m., NF5 stated resident #67 had discharged from the facility last week, and they were still missing an iPad, an apple watch, and clothing. NF5 stated she had requested resident #67's inventory sheet.</p> <p>A review of resident #67's [Facility Name] Healthcare: Personal Belonging Inventory showed resident #67's iPad and apple watch were inventoried. A grievance was not resolved for the lost items.</p> <p>Refer to F584 - Safe, Clean, Comfortable Environment for more details related to lost items, and greivances not initiated to address the lost items.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>51133</p> <p>Based on interview and record review the facility failed to refer resident #62 for a PASARR Level II when the diagnosis of Post Traumatic Stress Disorder was added for 1 (#62) of 25 sampled residents. Findings include:</p> <p>Review of resident #62's PASARR Level I, dated 6/21/24 lacked the diagnosis of Post Traumatic Stress Disorder.</p> <p>Review of resident #62's history and physical, dated 6/16/24 showed, .Social History .He does state he was in the special forces in the Korean war and Vietnam war, and at one point was a prisoner of war for 60 days, but escaped . [sic]</p> <p>Review of resident #62's MDS, with an ARD of 6/27/24, section I6100 showed the resident did not have a diagnosis of Post Traumatic Stress Disorder.</p> <p>Review of resident #62's MDS, with an ARD of 9/22/24, section I6100 showed the resident did have a diagnosis of Post Traumatic Stress Disorder.</p> <p>During an interview on 1/16/25 at 8:45 a.m., staff member C stated when the diagnosis of PTSD was added to the resident's diagnoses, a new PASRR Level 1 should have been completed. The Level 1 would then show if a Level II was necessary.</p> <p>A request was made for a Level II for resident #62's, and there was no information provided prior to the end of survey.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>44769</p> <p>Based on interview and record review, the facility failed to include on a resident's baseline care plan that the resident received enteral tube feedings, for 1 (#281) of 25 sampled residents. This deficient practice increased the risk of the resident not receiving proper tube feedings, or receiving food items, and the resident was NPO. Findings include:</p> <p>A review of a facility document, titled Respite Resident . [Resident #281], showed:</p> <p>Daily routine and how to care for patient while he's ready,</p> <p>This report is from his wife.</p> <p>Hx of spinal cord injury, parkinson's (communication is minimal), aspiration pneumonia, .</p> <p>- Nothing by patients mouth d/t aspiration pneumonia. [sic]</p> <p>A review of resident #281's diagnoses in the facility's EHR showed:</p> <p>Dysphagia, Oropharyngeal Phase .</p> <p>Pneumonitis Due to Inhalation of Food and Vomit .</p> <p>A review of resident #281's provider orders in the facility's EHR, showed:</p> <p>Tube feeding instructions: Isosource 1.5 @ 70 ml/hr. Continuous, With 50 ml/hr free water flush. Every shift for Continuous G tube feedings. [sic]</p> <p>A review of resident #281's baseline care plan showed:</p> <p>Focus</p> <p>Potential for altered comfort related to: [sic], with a date Initiated of 01/10/2025</p> <p>Interventions</p> <p>Offer non-pharmacological interventions for PRN e.g. Offer distraction via snack or an activity, offer shower or bath, active listening and validation, offer ROM/massage, relaxation and breathing techniques, re-positioning, rest, ice/heat.</p> <p>Further review of resident #281's care plan failed to show he was NPO or an enteral feed.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25 at 3:54 p.m., Staff member I stated the admitting nurse would initiate the baseline care plan for a newly admitted resident. If the admitting nurse did not complete the baseline care plan, the floor nurse would complete any assessments that were not done, and finish the baseline care plan. Staff member I stated a resident who was an enteral feed would definitely need that in their baseline care plan.</p> <p>A review of a facility policy, titled, Care Plans, Comprehensive and Revisions, with a revised date of December 2016, showed:</p> <p>Policy Statement</p> <p>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 .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46400</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received the required assistance at meals, for 1 (#5); and failed to ensure a resident received assistance with toileting and dressing for 1 (#58) of 25 sampled residents. Findings include:</p> <p>1. During an observation and interview on 1/14/25 at 7:57 a.m., staff member G stated they were the only staff member available to pass medications and food trays. Staff member G stated they would have to stop med pass if there was a resident who required assistance with eating. Resident #5 was sitting at a table attempting to feed himself.</p> <p>During an observation on 1/14/25 at 8:30 a.m., resident #5 was still eating breakfast, only now with staff assistance.</p> <p>During an observation on 1/15/25 at 8:21 a.m., resident #5 was attempting to eat a yogurt. He was bringing the empty spoon from the yogurt container to his mouth. He was not receiving any staff assistance or cueing.</p> <p>During an observation on 1/15/25 at 12:20 p.m., resident #5 was trying to use the handle of a spoon as a straw to consume fluids at lunch. He was not receiving any staff assistance or cueing.</p> <p>Review of resident #5's Quarterly MDS, with an ARD of 11/13/24, showed under section GG Functional Abilities: Eating: the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident, was marked as: Dependent.</p> <p>Review of resident #5's care plan, most recent revision date of 11/13/24, showed the resident required extensive assistance by 1 staff to eat.</p> <p>51133</p> <p>2. During an interview on 1/13/25 at 3:29 p.m., resident #58 stated that she has Parkinson's and needed assistance to use the bathroom. She stated staff believes she is more independent than she is. She further stated that her ability to use the bathroom fluctuates with the diagnosis of Parkinson's.</p> <p>Review of resident #58's diagnoses list showed she had a diagnosis of NEED FOR ASSISTANCE WITH PERSONAL CARE.</p> <p>During an observation on 1/14/25 at 2:25 p.m., resident #58 had her call light on and was heard calling for help from her bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 1/14/25 at 2:32 p.m., resident #58 was observed on her bed, wearing only underwear and shoes on her lower extremities, struggling to put her pants on, and was visibly upset and crying. Resident #58 was observed attempting to put her pants on inside out and stated, My pant is caught on my [expletive] shoe, and all I need is someone to help me. When asked if a CNA assisted her with using the toilet, she stated the CNA turned the call light off, left the room, and did not assist her with putting on her clothing.</p> <p>During an interview and observation on 1/14/25 at 2:35 p.m., this surveyor informed a staff member walking down the hall that resident #58 needed assistance. Staff member U assisted resident #58 to the bathroom in the room next door. When resident #58 was finished in the bathroom she returned to her room, and the resident's pants were observed inside out.</p> <p>Review of resident #58's care plan showed:</p> <p>Focus: HEALTH MAINTENANCE: related to Parkinson's, . Interventions . Provide assistance with ADLs as needed;</p> <p>Focus: The resident has an ADL self-care performance deficit r/t Activity Intolerance, Parkinson's with Impaired balance, and impaired gait, and muscle stiffness .Interventions . DRESSING: The resident requires set-up with upper/lower body dressing . TOILET USE: The resident requires supervision of one staff for toileting</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46400</p> <p>Based on interview and record review the facility failed to ensure hospice referrals were completed timely for 2 (#s 14 and 29) of 3 residents sampled for hospice concerns. Findings include:</p> <p>1. Review of resident #14's nursing progress notes, dated 12/15/24, showed an order was received for a hospice referral, dated 12/10/24, due to weight loss and senile degeneration of the brain. This was also shown on the resident's physician orders, dated 12/10/24.</p> <p>Review of resident #14's IDT progress notes, dated 12/16/24, showed the resident had a significant fall and was sent to the ER. Preventative measures listed for further fall prevention showed, She will be transitioning to hospice.</p> <p>Review of resident #14's nursing progress notes, dated 12/29/24, show a hospice referral order was signed by the provider and placed on 12/21/24. This was eleven days after the first hospice order was completed.</p> <p>Review of resident #14's nursing progress notes, dated 1/12/25, showed the residents POA wanted to start hospice for the resident. This progress note was one month after the initial order.</p> <p>During an interview on 1/14/25 at 9:26 a.m., staff member F stated nursing was unable to keep track of lab results, new orders, and referrals (such as hospice) due to staffing.</p> <p>During an interview on 1/15/25 at 1:43 p.m., staff member C stated while working on several hospice referrals, they were told hospice admissions were two weeks out.</p> <p>During an interview on 1/15/25 at 3:04 p.m., NF2 stated [facility name] hospice could usually get patients admitted in a week if they received all the documentation, or sooner, if it was felt the resident was very acute.</p> <p>50245</p> <p>2. Review of the facility's Grievance Report Form, dated 9/17/24, showed: [NF4] wants her on palliative care.</p> <p>Review of resident #29's physician's order, dated 12/16/24, showed: Hospice Referral r/t severe pain/post CVA.</p> <p>Review of resident #29's physicians order faxed to [Facility Name], dated 12/20/24, showed: Agree with Hospice referral.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46400</p> <p>Based on observation, interview, and record review, the facility failed to ensure there was adequate staff supervision on the memory care unit for 3 (#s 22, 45, and 62); failed to identify, implement, and provide sufficient interventions for a resident who eloped, for 1 (#276) ; and failed to ensure 2 (#s 2 and 28) were properly positioned when eating food for 40 sampled and supplemental residents. Findings include:</p> <p>1. During an interview on 1/13/25 at 3:00 p.m., staff members G and H stated the unit currently had a lot of residents with behaviors. They stated there were three staff scheduled for the mornings and two in the afternoons. Staff members G and H stated it was not enough staff with so many residents with behaviors and explained that there always needs to be one person supervising in the day room, so if a resident needed assistance in their room, staff would be spread pretty thin.</p> <p>During an observation on 1/14/25 at 10:00 a.m., resident #45 was standing in resident #62's doorway. Resident #62 was very agitated and wheeling towards resident #45, making verbal threats towards her if she did not get out of his doorway. This surveyor was the only one on the hall, and had to go flag down a staff member to intervene with the two residents.</p> <p>2. During an observation on 1/15/25 at 8:03 a.m., the surveyor was standing alone in the hallway while resident #22 was walking in the hall barefoot, holding an upright steele fork, in front of her. Her steps and gait were clumsy and rushed. Staff were busy assisting other residents in the dining room and did not intervene until several minutes later.</p> <p>Review of resident #22's nursing progress notes, dated 12/4/24, showed, Resident's . Syndrome causes movement and/or balance disorders . she ambulates with unstable gait . she often 'hurries,' as she's ambulating, increasing the risk for injury .</p> <p>Review of resident #22's care plan, with a most recent revision date of 1/12/25, showed under the interventions for fall risk, Please make sure I have appropriate footwear or non-slip socks which were not on the resident's feet during the observation by the surveyor.</p> <p>50245</p> <p>3. During an interview on 1/15/25 at 1:02 p.m., staff member J stated, I don't really know (the purpose), regarding resident #276's wanderguard. Staff member J stated they had a concern of the inefficiency of the system as there were multiple doors that the wanderguard did not work which resident #276 had access to. Staff member J stated there were two doors that would lock when the wanderguard was near them, but two other doors in the facility (one on E wing and one on A wing) did not lock when a wanderguard was near them. Instead, if any individual would push on the door for 15 seconds, an alarm would go off, but eventually the door would open. Staff member J stated this was how resident #276 had gotten out of the facility on 1/8/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Kalispell Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/15/25 at 3:56 p.m., staff member C stated, We dropped the ball on that, when referring to resident #276's elopement. Staff member C stated there were two extra exit doors that do nothing in response to a wanderguard.</p> <p>During an observation on 1/16/25 at 11:05 a.m., the transitional care unit was shown to have access to all residents in the facility except the memory care unit. Resident #276 did not reside in the memory care unit. This unit was not supervised by staff and had an additional door with outside access, as well as two doors, that went to an outside courtyard.</p> <p>4. During an observation on 1/14/25 at 8:38 a.m., resident #2 was laying back in her chair facing sideways to the table. Resident #2 was coughing while eating. Staff member M stated, Why don't you try and take a drink real quick? Resident #2's face was red in color.</p> <p>During an observation on 1/14/25 at 8:40 a.m., resident #2 continued to cough. Staff member M stated, Do you want something besides the eggs? Resident #2 did not answer and continued to cough. No other interventions were completed at this time. Staff member M asked the resident if she wanted yogurt. Resident #2's mouth was moving slightly but no words were voiced. Resident #2 nodded her head yes.</p> <p>During an observation and interview on 1/14/25 at 8:43 a.m., resident #2 stated she had learned how to spit out food when she was having a hard time swallowing.</p> <p>Review of resident #2's Dietary Order showed: Texture: Soft & Bite-Sized . and Notes: upright 90 degrees in bed, or in chair. Small bites/sips, alternate solids/liquids.</p> <p>During an observation on 1/14/25 at 8:46 a.m., resident #2 took a large bite of yogurt. Staff member M was no longer at resident #2's side.</p> <p>During an observation and interview on 1/14/25 at 8:46 a.m., staff member N asked how resident #2 felt and she stated, Winded. Staff member N obtained a pulse of 65 and an oxygen saturation of 95%. Staff member N began to listen to resident #2's heart and lungs. Staff member N asked resident #2 to sit forward so that she was able to access her back for lung auscultation, but resident #2 was still holding a spoonful of yogurt and was not able to grab the chair for assistance to help pull herself up. Staff member N was only able to access resident #2's upper back for lung auscultation. The resident did not take a deep breath during auscultation. During the lung auscultation, staff member N stated the left upper quadrant of the abdomen was the lower part of the lung field. There was no intervention to change the resident's position, take the food away temporarily, or ask resident #2 to stop, chew or swallow.</p> <p>Staff member N stated resident #2 looked tired and her cheeks were rosy in color. Staff member N stated she was checking vitals and lung fields on resident #2 because the resident stated she was unable to breathe. Staff member N stated resident #2 was slouched back in her chair and did have issues swallowing at times. Staff member N stated there was a decent amount of yogurt on the spoon, and the spoon was large in size for a resident who should be taking smaller bites.</p> <p>During an observation on 1/14/25 at 8:58 a.m., resident #2 was sitting straight up and now facing the table.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/15/25 at 1:02 p.m., staff member J stated drooling, coughing, a person's face turning red, and/or no words would be a concern for choking.</p> <p>5. During an observation on 1/15/25 at 8:58 a.m., staff member T brought in a food tray to resident #28. Staff member T asked resident #28 if she had felt comfortable eating in the flat position and then left.</p> <p>During an interview and observation on 1/15/25 at 9:00 a.m., resident #28 stated staff usually pull her up in a seated position to eat. Resident #28 stated she was able to swallow better if she was upright instead of a laying down position. Upon observation, resident #28 had her pillow fluffed up around her face with her neck kinked. As she was eating, she dropped a piece of sausage on her chest and lost it.</p> <p>During an interview on 1/15/25 at 9:13 a.m., staff member O stated the laying position of resident #28 could be a choking hazard especially with her specialized diet: minced and moist.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>46400</p> <p>Based on observation, interview, and record review, the facility failed to ensure pain was routinely assessed and treated according to professional standards for 3 (#s 10, 29, and 30), especially concerning pain management for a resident with advanced dementia for 1 (#14); and failed to failed to properly follow physician orders regarding pain monitoring documentation for 1 (#10) of 25 sampled and supplemental residents. Findings include:</p> <p>1. During an observation and interview on 1/13/25 at 3:24 p.m., resident #14 was sitting at the table in the memory care unit main area. She had a distressed look on her face and was rocking in the chair. Staff member G stated resident #14 was restless and cried a lot.</p> <p>During an interview on 1/15/25 at 9:04 a.m., staff member C stated there were usually med aides staffed on the memory care unit, which required the nurse to run around the building doing treatments and prn medication assessments.</p> <p>During an observation on 1/16/25 at 8:30 a.m., resident #14 was sitting at the table with a full plate of food in front of her. She wasn't eating, but was instead sucking on the clothing protector, and she appeared to be wincing with her facial expression.</p> <p>During an observation and interview on 1/16/25 at 8:40 a.m., resident #14 was sitting on the couch underneath several blankets. She was grimacing and apprehensive. Staff member J stated the resident had been experiencing failure to thrive. She stated it was difficult to tell if the resident was in pain or anxious, although she had been on Ativan [antianxiety medication], for forever.</p> <p>Review of resident #14's medication administration reports for December 2024 and January 2025 showed the resident had twice daily scheduled antianxiety medication and no scheduled pain medication, only prn orders.</p> <p>Review of resident #14's Quarterly MDS, with an ARD of 12/25/24, showed the BIMS interview was not completed because the resident was rarely/never understood.</p> <p>Review of resident #14's care plan, revised 7/9/24, showed, The resident has unclear speech that is often nonsensical. She sometimes understand what is said to her and can rarely make herself understood. [sic]</p> <p>Review of resident #14's pain monitoring for December 2024 showed: 15 missed opportunities out of 62.</p> <p>Review of resident #14's pain monitoring for January 2025 showed five missed opportunities out of 30. Two pain assessments on 1/7/25 were documented at a pain level of four, without any correlating pain medication given, as documented on the medication administration record.</p> <p>Review of resident #14's nursing progress notes, dated January 2025, showed:</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 1/1/25 Behaviors . patient sitting on edge of couch moaning, crying out, and rocking. After assessment patient administered narcotic pain medication for pain level 4/10 on facial scale.</p> <p>- 1/7/25 Defiant cares include physically pushing back on staff, becoming rigid .</p> <p>- 1/7/25 Resident with behaviors of resistance, such as whimpering, lifting her feet when staff attempt to transfer her . will refuse staff by pushing back on them .</p> <p>- 1/8/25 . CNA stated she (resident) was rigid and pushed back towards staff when they were transferring her .</p> <p>- 1/9/25 Resident pushing back on staff with ADL cares . whimpering .</p> <p>According to the, Pain Assessment in Advanced Dementia (PAINAD) Scale</p> <p>A five-item observational tool [Breathing, negative vocalizations, facial expression, body language, and consolability] with scores ranging from 0-10, based on a scale of 0-2 for each item, with a higher score indicating more severe pain.</p> <p>Negative vocalization:</p> <p>0= None</p> <p>1= Occasional moan or groan. Low level speech with a negative or disapproving quality</p> <p>2= Repeated troubled calling out. Loud moaning or groaning. Crying.</p> <p>Facial Expression:</p> <p>0= Smiling or inexpressive</p> <p>1= Sad. Frightened. Frown.</p> <p>2= Facial grimacing</p> <p>Body Language:</p> <p>0= Relaxed</p> <p>1= Tense. Distressed pacing. Fidgeting.</p> <p>2= Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.</p> <p>50245</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During an interview and observation with NF4 and resident #29, on 1/13/25 at 3:16 p.m., resident #29 stated she had waited over an hour after requesting Tylenol for pain management. Resident #29 stated she very frequently had pain in her left hip and had to wait for pain medication. NF4 stated this had been an ongoing problem and had even requested for resident #29 to be on hospice or palliative care to receive effective pain management. NF4 stated resident #29's pain affected her ability to move and be repositioned with staff. NF4 stated resident #29 often refused being turned which caused even more concern for skin breakdown. NF4 pointed to a diagram of on the wall that the facility depicted as the proper positioning of resident #29 with pillows offloading common pressure points. Resident #29 stated the staff did not use the diagram anymore because of how often repositioning hurt her. Observation of the diagram, showed a placement of four pillows underneath resident #29's left side of her body. Resident #29 had only one pillow underneath her head during the interview/observation.</p> <p>Review of resident #29's physician order's, dated 12/16/24, showed: Hospice Referral r/t severe pain/post CVA.</p> <p>Review of resident #29's EHR showed a physician's order, dated 9/30/24: Resident to be placed on palliative care.</p> <p>During an interview on 1/15/25 at 1:02 p.m., staff member J stated the facility did not have palliative care and they (a resident) would usually go right to hospice (if needed). Staff member J stated the palliative care physician's order for resident #29 was unclear and this doesn't make any sense.</p> <p>3. During an interview on 1/14/25 at 2:13 p.m., resident #10 stated he had pain everyday and all over. He stated, Couldn't tell you, when he referred to the last time a staff member had asked him to rate his pain on a scale of 0-10. He stated he had asked staff to change his pain medication to something else because he felt his pain was not managed. He stated the staff did not rotate him and he stated, I wouldn't refuse (repositioning). He stated, They're always understaffed and too busy.</p> <p>During an interview on 1/15/25 at 1:50 p.m., staff member G stated they always asked residents what their pain rating was using the 0-10 pain scale, prior to and after, giving a medication. Staff member G stated this was documented in the EHR. Staff member G stated resident #10 received scheduled pain medication, but was known to have pain frequently, especially if it was after a bath or eith movement.</p> <p>Review of resident #10's EHR showed the following diagnoses: Spondylosis without myelopathy or radiculopathy, lumbar region; arthropathic psoriasis; polyneuropathy, spinal stenosis lumbar region with neurogenic claudication; wedge compression fracture of unspecified thoracic vertebra; other intervertebral disc degeneration, lumbar region.</p> <p>Review of resident #10's EHR, from 12/1/24 to 1/13/25, showed:</p> <p>-11 missed pain assessments on: 12/1/24, 12/13/24 (day and nightshifts), 12/14/24, 12/23/24, 12/24/24, 12/26/24, 12/29/24, 12/30/24, 1/3/25, and 1/11/25.</p> <p>-All pain assessments were assessed at a 0/10, except for 10 of the 87 shifts reviewed.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #10's physician order, with a start date 4/9/24, showed: Pain Monitoring: Monitor for verbal and/or non-verbal signs of pain. If the pain scale is scored 5 or more complete pain progress note.</p> <p>Review of resident #10's nursing notes showed no pain progress notes were completed referencing resident #10's pain rating at a 5/10 or higher (on the dates 12/14/24, 12/15/24, and 12/18/24).</p> <p>4. During an interview on 1/15/25 at 1:43 p.m., resident #30 stated, What's that?, when referring to the pain scale of 0-10. Resident #30 stated his pain usually was at a three, but could be at a six at the worst.</p> <p>Review of resident #30's EHR showed the diagnoses: polyneuropathy and pain in the left shoulder.</p> <p>Review of resident #30's EHR, from 11/1/24 to 1/15/25, showed:</p> <p>-10 missed pain assessments on: 12/1/24, 12/5/24, 12/13/24 (day and nightshifts), 12/23/24, 12/24/24, 12/29/24, 12/30/24, 1/3/25 and 1/11/25.</p> <p>-All pain assessments were rated at a 0/10, except for 13 of the 152 shifts reviewed.</p> <p>The facility's pain management policy was requested and documented as requested on the survey team's request sheet #4, which was provided to the facility. No policy or documentation was provided by the facility by the end of the survey.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>50245</p> <p>Based on interview and record review, the facility failed to ensure resident's call lights were answered timely for 6 (#s 10, 12, 26, 29, 30, 32) of 40 sampled and supplemental residents, leading residents to feel their pain was not adequately managed. Findings include:</p> <p>1. During an interview on 1/13/25 at 4:17 p.m., resident #30 stated he often waited over 30 minutes for his call light to be answered. He stated he waited the longest for his call light to be answered at night, and he felt the facility and staff were understaffed and overworked.</p> <p>During an interview on 1/13/25 at 4:29 p.m., resident #32 stated he felt the facility was understaffed as he frequently waited 30 minutes for his call light to be answered.</p> <p>During an interview on 1/13/25 at 4:33 p.m., resident #10 stated he often waited over 30 minutes 15 times in a week for his call light to be answered. Resident #10 also stated the longest call light wait time was over an hour.</p> <p>During an interview on 1/13/25 at 3:56 p.m., resident #12 stated the facility only had two CNAs at night. She stated, I'm sick and tired of them (the facility) claiming they are overstaffed. Resident #12 stated she had to wait the longest at night for her call light to be answered and she stated, They (the facility) have everyone (staff members) trained to turn off your call light (off) without assessing needs. Resident #12 stated she felt slightly unsafe, as there were over 60 residents, and only five staff members. She stated the facility used to ask quarterly if residents felt safe in their environment, but they do not anymore.</p> <p>During an interview on 1/14/25 at 7:56 a.m., resident #26 stated there was not enough staff especially on the weekends and at night. Resident #26 stated every night at 9:00 p.m. or 10:00 p.m., it would take 30 minutes for staff to answer her call light.</p> <p>During an interview on 1/14/25 at 9:26 a.m., staff member F stated, We don't have adequate amounts of staffing due to (the) nursing budget. Staff member F stated it was common to have one nurse and one CNA on the E wing. Staff member F stated she had concerns for the low staffing ratios, especially when two people were needed to operate a mechanical lift. Staff member F stated they are told to just make do, when concerns were expressed to upper management.</p> <p>During an interview on 1/15/25 at 1:02 p.m., staff member J stated there had been times where there was only one nurse for the entire building for 70 residents. Staff member J stated there were medical aides, but those staff were unable to administer insulin, check a blood glucose, or give PRN medications. Staff member J stated the nurse was responsible for those duties, along with the charting, which included all assessments (such as monitoring assessments, bruise monitoring assessments, skin assessments, wound assessments and treatments, etc.) for the entire building if there was not another nurse scheduled.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. During an interview with NF4 and resident #29, on 1/13/25 at 3:16 p.m., resident #29 stated she had waited over an hour after requesting a Tylenol for pain management. Resident #29 stated she very frequently had pain in her left hip and had to wait for pain medication. NF4 stated this had been an ongoing problem at the facility.</p> <p>During an interview on 1/14/25 at 2:13 p.m., resident #10 stated he had pain everyday and all over. He stated staff were frequently very busy and he felt his pain was not managed effectively. He stated staff did not offer to rotate (reposition) him and he stated, I wouldn't refuse, if staff would offer to help him move in the bed. He stated, They're always understaffed and too busy.</p> <p>Review of resident #10's EHR showed the following diagnoses: Spondylosis without myelopathy or radiculopathy, lumbar region; arthropathic psoriasis; polyneuropathy, spinal stenosis lumbar region with neurogenic claudication; wedge compression fracture of unspecified thoracic vertebra; other intervertebral disc degeneration, lumbar region. [sic]</p> <p>During an interview on 1/15/25 at 4:17 p.m., staff member A stated call light times were determined by resident satisfaction.</p> <p>Review of a facility document, titled Call Light Audit, showed . 5 minute goal. Never walk past a call light.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>51133</p> <p>Based on interview and record review, the facility failed to ensure a resident received services for the treatment of post traumatic stress disorder, for 1 (#62) of 25 sampled residents. Findings include:</p> <p>During an interview on 1/13/25 at 4:14 p.m., resident #62 stated he was a Veteran; and, I saw a lot of combat in Korea and Vietnam. I have PTSD.</p> <p>Review of resident #62's history and physical, dated 6/16/24 showed, .Social History . He does state that he was in the special forces in the Korean War in Vietnam war and at one point was a prisoner of war for 60 days but escaped[sic]</p> <p>During an interview on 1/15/25 at 8:14 a.m., resident #62 stated, I need to see a psychiatrist or a counselor for my PTSD.</p> <p>Review of resident #62's list of diagnoses list showed the resident had a medical diagnosis of post-traumatic stress disorder.</p> <p>During an interview on 1/16/25 at 8:45 a.m., staff member C stated resident #62 had not been referred for treatment related to the post traumatic stress disorder.</p> <p>A request was made for documentation showing a referral was made for the treatment of resident #62's PTSD, but nothing was received prior to the end of survey.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>44769</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on interview and record review, facility nursing staff failed to administer two medications during the evening medication administration time, that were ordered to be given two times a day for 1 (#76) of 25 sampled residents. This resulted in a 6.4 percent medication error rate. This deficient practice had the potential to adversely affect the resident who was taking an antibiotic two times a day for pneumonia, and Potassium Chloride two times a day for encephalopathy. Findings include:</p> <p>A review of resident #76's EHR showed a physician's order for the antibiotic, Cefdinir, 300 mg., with an order date of 9/6/2024 at 12:40 p.m., which showed, Give 1 capsule by mouth two time a day related to Pneumonia .</p> <p>A review of a medication order in resident #76's EHR showed an order for Potassium Chloride, 10 meq. with, an order date of 9/6/2024 at 3:27 p.m., which was, Give 2 capsule by mouth two times a day related to Encephalopathy . [sic]</p> <p>A review of resident #76's MAR showed the medications, Cefdinir and Potassium Chloride, was not documented as given for the 9/6/24 medication pass at 5:00 p.m.</p> <p>During an interview on 1/14/25 at 10:40 a.m., staff member G stated if the medication was not marked off in the MAR as given, it was a medication error, and there's no excuse.</p> <p>During an interview on 1/16/25 at 8:02 a.m., staff member D stated if the medication was not checked off in the MAR, it wasn't given.</p> <p>A review of a facility policy, titled, Administering Medications, with a revision date of December 2012, showed:</p> <p>Policy Statement</p> <p>Medications shall be administered in a safe and timely manner, and as prescribed.</p> <p>Policy Interpretation and Implementation .</p> <p>3. Medications must be administered in accordance with the orders, including any required time frame .</p> <p>18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document this information in the MAR accordingly.</p> <p>19. The individual administering the medication must document in the resident's MAR in the applicable section after giving each medication and before administering the next resident's medications</p>		

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

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide or obtain dental services for each resident.</p> <p>46400</p> <p>Based on observation, interview, and record review, the facility failed to follow up on referrals for dental care for 5 (#s 3, 5, 6, 48, 280) of 40 sampled and supplemental residents. Findings include:</p> <p>1. Review of resident #5's nursing progress notes, dated 4/15/24, showed the resident had been seen by the dental hygienist, and the concerns identified included:</p> <ul style="list-style-type: none"> - Possible decay of 5, 6, 11, 23, 24, 25, 26, 27, 28. - Broken teeth 21 and 22. - Root tips present 3, 4, 7, 8, 10, 14, 20, 30, 31. <p>Review of resident #5's EHR, accessed on 1/13/25, showed there was a physician's order for a dental referral dated 4/15/24. Review of the resident's EHR failed to show any progress notes or followup referrals or treatment for the resident's identified dental concerns.</p> <p>During an interview on 1/15/25 at 8:33 a.m., staff member B stated the facility had the referral in May (2024), but did not follow up, and they would make the appointment today (1/15/25).</p> <p>50245</p> <p>2. a. During an interview on 1/13/25 at 4:37 p.m., resident #48 stated some of the foods (like chicken) were tough to eat, and she had a hard time eating them because her dentures did not fit properly.</p> <p>Review of resident #48's EHR showed a 6.15% weight loss. The resident's weight was 128.4 pounds on 11/4/24, and the weight went down to 120.5 pounds on 1/13/25.</p> <p>b. During an interview on 1/14/25 at 2:50 p.m., resident #3 stated her dentures would slip, which made it hard for her to eat.</p> <p>c. During an interview on 1/15/25 at 9:19 a.m., resident #6 stated her dentures did not fit properly so she did not wear them at all.</p> <p>d. During an interview and observation on 1/15/25 at 8:33 a.m., resident #280 stated his dentures did not fit well which made it difficult to chew meats. Resident #280 had left two sausage links on his plate, and he stated he would not be able to chew them. Resident #280 stated he might not get enough protein for his renal diet.</p> <p>A request was made for resident #3, #6, and #48's dental notes and appointments. No documentation was provided by the end of the survey.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>50245</p> <p>Based on observations and record review, the facility failed to follow the posted menu for two meals of the three observed meals, which could affect any resident wishing to utilize the posted menu's. Findings include:</p> <p>During three observations on 1/14/25 at 8:33 a.m., 8:37 a.m., and 8:41 a.m., whole grain toast was not observed on a resident's plate.</p> <p>Review of the 1/14/25 breakfast menu showed:</p> <ul style="list-style-type: none"> . Whole grain toast <p>During an observation on 1/15/25 at 12:37 p.m., the following foods were served for lunch:</p> <ul style="list-style-type: none"> - Potato soup - Ham and cheese on a croissant - Watermelon - Cupcake <p>Review of the 1/15/25 Lunch Menu showed:</p> <ul style="list-style-type: none"> Garden vegetable soup Classic beef stroganoff Lemon buttered broccoli Baked roll Raspberry jello salad <p>The menu items posed were not what was served that day.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245</p> <p>Based on observations, interviews, and record review, the facility dietary department and staff failed to serve food timely, and follow the posted meal times, and food was often served late which resulted in cold food, for 5 (#s 6, 10, 28, 35, and 41) of 40 sampled and supplemental residents; and 3 (#s 29, 48, 49) of 25 sampled and supplemental residents stated they disliked the food. Findings include:</p> <p>1. Review of a facility document, titled Mealtimes, showed, .Dining room [ROOM NUMBER]:00 (a.m.) Breakfast .</p> <p>During an observation on 1/14/25 at 8:28 a.m., breakfast was being served in the dining room.</p> <p>During an interview on 1/14/25 at 8:31 a.m., resident #6 stated the food was typically served 30 minutes late, but could be served up to an hour late. Resident #6 stated yesterday breakfast was 30 minutes late in the dining room.</p> <p>Review of a facility document, titled Mealtimes, showed, .E and D Wing 8:30 (a.m.) Breakfast .</p> <p>During an interview on 1/15/25 at 8:07 a.m., resident #41 stated her food was served later than 8:30 a.m. on wing E and was usually cold.</p> <p>During an observation on 1/15/25 at 8:16 a.m., breakfast was served in the dining room.</p> <p>During an observation on 1/15/25 at 8:58 a.m., resident #28 who resided in E wing was served breakfast.</p> <p>During an interview on 1/15/25 at 9:07 a.m., resident #35 stated her eggs were almost always cold in the morning, when her tray was delivered to her room, in the E wing.</p> <p>During an observation on 1/15/25 at 9:16 a.m., staff member T was serving the last few breakfast trays to E wing.</p> <p>Review of a facility document, titled, Mealtimes, showed, .A and C Wing 12:30 (p.m.) Lunch .</p> <p>During an interview on 1/15/25 at 12:48 p.m., resident #10 stated the food delivered to his room on the A wing was often delivered late and was cold.</p> <p>2. During an interview on 1/13/25 at 3:16 p.m., resident #29 stated she did not like the food served at the facility and had her family member bring in her food for every meal.</p> <p>During an interview and observation on 1/14/25 at 8:33 a.m., resident #48 stated she would have preferred some milk to make her oatmeal less thick. Upon observation, there was a large thick clump of oatmeal in resident #48's bowl. Resident #48's meal ticket showed lactose free milk, but no milk product was on resident #48's tray.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 1/14/25 at 8:37 a.m., resident #49 was picking out blackened pieces of food in her eggs. Resident #49 stated, That's just no, when pointing to the blackened pieces of egg that looked like burnt food particles.</p> <p>During an interview on 1/14/25 at 9:26 a.m., staff member F stated, (The) food is disgusting most of the time.</p> <p>During an interview on 1/15/25 at 1:02 p.m., staff member J stated, Pretty much everyone here hates the food, and the residents told staff member J the food was jail food.</p>

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>50245</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the physician ordered therapeutic diet was followed for 3 (#s 12, 48, 280) of 40 sampled and supplemental residents. Findings include:</p> <p>a. During an interview on 1/13/25 at 3:56 p.m., resident #12 stated, (It was) unfortunate that the kitchen is not required to do a better job for diabetics. Resident #12 stated her blood sugar was commonly very high since being admitted to the facility, and she would often bring her own food. Resident #12 stated lunch that day was chili, coleslaw, spiced apples, yogurt (not low sugar), and carrot cake. Resident #12 stated this was too many carbohydrates for her to eat as a diabetic.</p> <p>Review of resident #12's EHR showed: CCHO diet.</p> <p>b. During an interview on 1/13/25 at 4:37 p.m., resident #48 stated she had to remind the staff to give her sugar free syrup because she stated they would forget and serve her regular syrup with breakfast, such as with waffles.</p> <p>Review of resident #48's EHR showed: CCHO diet.</p> <p>During an interview on 1/14/25 at 9:26 a.m., staff member F stated therapeutic diets were often not followed by the kitchen, they specifically pointed out how dialysis and diabetic diets were not being followed due to the budget.</p> <p>c. During an interview on 1/15/25 at 8:33 a.m., resident #280 stated he had a renal diet due to his diagnosis of end stage renal disease. Resident #280 also stated his dentures did not fit which made it difficult to chew meats. Resident #280 had left two sausage links on his plate and stated he would not be able to chew these. Resident #280 stated he might not get enough protein for his renal diet due to his concern for chewing meats.</p> <p>Review of resident #280's EHR showed: Regular diet, Soft & Bite Sized .</p> <p>Review of resident #280's diagnoses list showed: End Stage Renal Disease.</p> <p>Review of the Facility Matrix showed: resident #280 was marked as an offsite dialysis resident.</p> <p>During an interview on 1/15/25 at 1:02 p.m., staff member J stated residents with diabetic diets were receiving the same diet as all of the other residents with no dietary restrictions. Staff member J stated the only differences she noticed with therapeutic diets were textures. Staff member J stated no sugar free snacks were even an option for diabetic residents at the facility.</p> <p>During an interview on 1/16/25 at 9:54 a.m., staff member L stated they had never heard of a renal diet. Staff member L stated with a carbohydrate diet, gluten free breads were an important part of this diet, and panko could not be served with this specialty diet.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility document, titled Therapeutic Diets, revised 10/17, showed:</p> <p>.1. A therapeutic diet is considered a diet ordered by a physician, practitioner or recommended by a dietician ..</p> <p>8. Snacks will be compatible with the therapeutic diet .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46400</p> <p>Based on observation, interview, and record review, the facility failed to ensure transmission-based precautions were accurate and followed; failed to ensure documentation and notification of Covid tracing in residents was completed; and failed to have a system in place to prevent and monitor water borne illnesses. These infection control failures could affect any resident at the facility, to include 8 (#s 1, 6, 10, 20, 27, 31, 32, and 280) of 40 sampled and supplemental residents; and the failure to have a waterborne pathogen program in place which could affect any resident residing at the facility. Findings include:</p> <p>1. During an observation on 1/15/25 at 8:51 a.m. staff member K was observed in resident #280's room. The sign on the door showed the resident was under contact precautions, and staff were required to wear gown and gloves. The resident was also on Enhanced Barrier Precautions for direct care activities. Staff member K was not wearing any personal protective equipment in the room.</p> <p>During an observation on 1/15/25 at 9:39 a.m., staff members K and C were in resident #280's room without any personal protective equipment.</p> <p>During an observation on 1/15/25 at 10:57 a.m., there was a contact precautions sign on the room door for resident #10 and #32.</p> <p>During an interview on 1/15/25 at 11:00 a.m., staff member G stated she knew the room [resident #10 and #32] had enhanced barrier precautions, but did not know why either resident would be on contact precautions.</p> <p>During an observation on 1/15/25 at 11:05 a.m., there was a contact precautions sign on resident #1's door.</p> <p>During an interview on 1/15/25 at 11:09 a.m., staff member D stated resident #280 was the only resident who should be on contact precautions, which was for shingles. Staff member D stated someone must have gotten confused and put up the signs for resident #'s 1, 10, and 32.</p> <p>Review of the facility policy, Isolation - Categories of Transmission-Based Precautions, dated 3/2023, showed:</p> <p>Contact precautions</p> <p>. 5. Gown</p> <p>a. Wear a disposable gown upon entering the Contact Precautions room or cubicle .</p> <p>2. During an interview on 1/15/25 at 9:53 a.m., staff member D stated if there were any Covid positives (tests) among staff the facility would test the exposed residents on days one, three, and five. Progress notes would show the resident test results.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/15/25 at 10:32 a.m., staff member D stated a staff member had tested positive for Covid the day prior. They were testing the five residents who had been close contacts. These included resident #s 6, 20, 27, 31, and 32.</p> <p>Review of nursing progress notes for resident #s 6, 20, and 27 failed to show a progress note reflecting they had been tested for Covid on 1/14/25, or the test results.</p> <p>During an observation and interview on 1/15/25 at 10:34 a.m., resident #20 was wearing oxygen. Staff member H stated the resident had prn oxygen, and had low sats that morning, so they had put the resident on oxygen. Staff member H was not aware resident #20 had been a close contact for the staff member who tested positive, and was in the Covid testing protocol.</p> <p>During an interview on 1/15/25 at 10:45 a.m., staff member D stated she had tested all close contact residents the day prior (1/14/25) but had forgotten to put a progress note in the resident record's, and had just now completed them. Staff member D stated everyone had tested negative.</p> <p>3. Review of the facility policy, Water-borne Contaminants, dated 12/16/19, showed, Approaches to controlling waterborne microorganisms (i.e., water system decontamination) will be consistent with current Centers for Disease Control and Prevention . recommendations or state and local health department requirements . designee is responsible to identify the facility's risk for water-borne contaminants . and to implement appropriate prevention measures .</p> <p>During an interview on 1/16/25 at 10:48 a.m., staff member E stated the facility did not have any procedures or systems in place for waterborne microorganisms.</p>		