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	03/12/2026

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

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to reposition and facilitate ambulation for 1 (#98) and this deficient practice resulted in the development of an avoidable Stage III pressure ulcer; and the facility failed to provide necessary positioning and repositioning for skin protection and the prevention of wound development, for 3 (#s 2, 71, and 73) of 38 sampled residents. Findings include:1. A review of resident #98's skin and wound care documentation showed the nursing staff identified a reddened area on the resident's coccyx due to pressure on 9/5/25. This reddened area then developed into a Stage III pressure ulcer. During the interview on 3/10/26 at 10:19 a.m., NF3 stated resident #98 had developed wounds while residing at the facility. NF3 stated resident #98 had walked before going into the facility and then was never taken for walks with staff or repositioned, so the resident developed a pressure ulcer on his coccyx. NF3 asked the facility to print papers to remind the staff to turn (reposition) resident #98, but those only stayed up for a week. NF3 stated the wound care nurse was doing care, but because the wound continued to worsen, he personally doubted the treatments were being done correctly or consistently. NF3 stated they made an appointment with the wound care specialist for resident #98, who later said the staging (severity) of the wound was almost to the bone. NF3 stated the family made an appointment with resident #98's primary care provider as they were concerned about him and his care. Review of resident #98's Weekly Skin Check Assessment, dated 8/29/25, showed resident #98's skin is intact, at that time. Review of resident #98's primary care physician's note from [external facility], showed: a pressure ulcer of sacral region, Stage III. During this appointment, a referral for physical therapy, occupational therapy, and the wound care clinic was made. The physician notes also showed: . (Resident #98) has developed decubitus ulceration impacting his right and left buttocks . is at least stage III. He has had some wound care at [the facility] however with the worsening of the wound, A formal wound care evaluation has been requested in our wound care clinic. Frequent moving and repositioning are recommended to prevent further deterioration. [sic] During an interview on 3/12/26 at 2:34 p.m., NF4 stated they had been with resident #98 during the primary care appointment, and it had taken two of the office nurses to stand him up. NF4 stated this was the first time they had seen the wound and had known of a wound on his coccyx. NF4 stated they had gone into the facility multiple times and tried to encourage the staff that they needed to turn him every two hours. NF4 stated they had a nurse print off two papers saying turn every two hours, but those were only up for a couple of weeks. NF4 stated they then printed off two papers from home and put them up above the resident's head (on wall) and on his door. NF4 stated that during the wound care appointments, the facility would forget to pack the resident's lift sling, so he could never have (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	his appointment. NF4 stated this happened with two of the three appts. Review of resident #98's EHR showed a Wound Care Visit note, dated 10/13/25, and the appointment was rescheduled because resident #98 was not sent with his lift sling under him. Review of resident #98's Wound Care Visit notes, dated 9/29/25, showed: an Unstageable pressure ulcer of the sacral region. The physician also noted: Provider Comments: This is a sad case of an [AGE] year-old man who was fairly independent at home with his wife when both had a fall. This was about 5 or 6 weeks ago. He has gone into a skilled nursing facility but was somewhat combative and confused and when sedated became more bedbound. This resulted in a sacral pressure injury of mixed depth across the injury. At this current level activity will be impossible to keep him from either having this injury or a different pressure injury. The Pressure Ulcer measures 13 cm x 11 cm x 0.1 cm . [sic] During an interview on 3/12/26 at 11:00 a.m., staff member T stated Haldol was contraindicated for a resident with dementia and stated there were other medications that could be used to help with behaviors. Staff member T stated the wound that developed on resident #98's coccyx was due to pressure. Staff member T stated they had only staged the wound as a deep tissue injury and that it was not measurable. Review of resident #98's progress note, dated 10/20/25, showed: . Please clarify treatment orders for coccyx wound. The wound is severe, with depth and tunneling. Review of resident #98's progress note, dated 10/19/25, showed: Coccyx wound is fleshy, black, deep with tunneling. 2. During an interview and observation on 3/10/26 at 9:36 a.m., resident #73 stated he had been in his motorized wheelchair a dozen times since being at the facility. Resident #73 stated, They don't get me in it, and he stated he had asked staff members about getting in the motorized wheelchair, but nothing changed. Resident #73 stated he also was not turned while he was in bed. He stated his buttock area hurt pretty often. He stated he would not refuse any staff members rotating him side to side or positioning him with any pillows. Resident #73 was lying on his back with no pillows used for positioning at the time of the observation. Review of resident #73's EHR showed an admission date of 8/11/25. During an observation and interview on 3/10/26 at 1:26 p.m., resident #73 stated he had gotten up for a few hours with physical therapy, but was back in bed since noon, and he had eaten his lunch. His shirt was covered with crumbs, and chocolate spread across his shirt from a muffin he had eaten. Resident #73 was on his back with no pillows used for positioning during the observation. During an observation on 3/10/26 at 5:02 p.m., resident #73 was lying in bed on his back with no pillows for positioning. During an observation on 3/11/26 at 7:33 a.m., resident #73 was lying in bed on his back with no pillows for positioning. During an observation on 3/11/26 at 9:39 a.m., resident #73 was lying in bed on his back with no pillows for positioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 3/11/26 at 10:39 a.m., resident #73 was in his motorized wheelchair with physical therapy. During an interview on 3/11/26 at 11:38 a.m., staff member W stated resident #73 never moved. Staff member W stated they recently put him back on rehab services because staff member W felt bad for resident #73, and he would just sit in bed all day. During an observation on 3/11/26 at 1:00 p.m., resident #73 was lying directly on his back. 3. During an observation on 3/10/26 at 7:41 a.m., resident #2 was in bed and lying on his back. tilted slightly to his left side. He had an ace bandage on his left forearm, and his left elbow was directly on the bed. Resident #2 had an open wound on his left elbow. During an observation on 3/11/26 at 7:35 a.m., resident #2 was lying on his back while lying on his left elbow. During an observation on 3/11/26 at 9:55 a.m., resident #2 was positioned on his back with his left elbow directly on the bed. His left elbow wound was undressed, and the wound dressing was stuck below on the catheter bag that was on the floor. See F880 for infection control concerns regarding catheters. During an observation on 3/11/26 at 1:01 p.m., resident #2 was lying directly on his back, and his left elbow was resting directly on the bed. Resident #2's elbow wound was undressed. 4. During an observation and interview on 3/10/26 at 5:14 p.m., resident #71 was lying directly on his back. He stated that facility staff did not rotate him in bed and stated his buttock area would hurt from sitting for a long time. During an observation on 3/11/26 at 7:34 a.m., resident #71 was lying on his back with no positioning pillows in place. During an interview on 3/11/26 at 2:50 p.m., staff member A stated there was documentation for residents being rotated. Staff member A stated that if a physician stressed a concern for rotating, the documentation would show specifically to rotate a resident every two hours, either towards the window or the door. Staff member A stated that this documentation would then be scanned into the EHR. A request was made for the repositioning documentation for residents #s 2, 71, 73, and 98. No documentation was provided by the end of the survey for the repositioning documentation. Review of a facility policy, titled Turning and Repositioning, dated 11/11/25, showed: . 1. All residents at risk of, or with existing pressure injuries, will be turned and repositioned, unless it is contraindicated due to a medical condition. In this case, small shifts in repositioning will be employed. 3. A routine turn schedule includes using both side-lying and back positions, alternating from the right, back, and left side. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	e. Avoid positioning the resident on surfaces with existing pressure injuries, including persistent redness.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to frequently encourage and facilitate ambulation for 1 (#98) of 38 sampled residents, and this contributed to resident #98 losing mobility and becoming bed-bound and developing a Stage III pressure wound. Findings include:During an interview on 3/10/26 at 10:19 a.m., NF3 stated his father was not taken care of at the facility. NF3 stated his father ambulated independently with a walker prior to a fall at home and being admitted to the hospital. NF3 stated the plan for resident #98 was to go to the facility and gain strength in order to go to an assisted living facility. While resident #98 was at the facility, NF3 stated staff would not ambulate resident #98 because he was a high fall risk and sometimes combative. NF3 stated he watched his father ambulate at the facility one time and most of the time they left him in his chair or in bed. NF3 stated resident #98 lost all mobility due to the facility not encouraging him to ambulate. NF3 stated the facility staff members had a very poor dementia approach and would not complete any cares if resident #98 showed behaviors. NF3 stated, I felt like my dad was angry about what was going on. NF3 stated the facility in return stated they could not force him to participate in cares and this was why the care was not being done. NF3 continued to explain a medication, Haldol, was given in error for at least five days, and friends that had visited during that time said he was like a zombie. NF3 also stated resident #98 developed pneumonia and a pressure ulcer that was almost to the bone while at the facility due to not moving or being repositioned. Refer to F686 Treatment/Services to Prevent Pressure Ulcers for more detail related to the pressure ulcer. During an interview on 3/10/26 at 2:34 p.m., NF4 stated she had visited resident #98 a few times a week. NF4 stated the resident had only been at the facility two months, deteriorated, and then passed away. She said she asked the staff why he was not walking, and the staff told her, We had no idea he could even walk. NF4 stated that when the resident was at home, he did not break anything, and he only stayed at the hospital because he did not have a caretaker at home and had dementia. Resident #98's wife needed surgery after they had both fallen at home, and she was his caretaker. NF4 stated that after a month had gone by at the facility, resident #98 could not get up on his own. NF4 stated they talked to the administrator about rehab services, about three weeks after the resident was admitted , but were told by the administrator that they would have to pay more because they were private pay.Review of resident #98's physician order, dated 9/26/25, showed: PT/OT evaluation and treatment for deconditioning.During an observation and interview on 3/11/26 at 11:38 a.m., staff member W showed a blank document on their computer screen showing that resident #98 never received PT or OT services. Staff member W stated, Looks like the orders never got to him. Staff member W stated there were orders for resident #98 to have PT and OT, but due to the resident being private pay, they had approached the family and offered rehab services instead. Staff member W stated the rehab department made an error and should have documented the conversation with the family, but they did not.During an interview on 3/11/26 at 12:40 p.m., staff member U stated resident #98 was agitated sometimes, but they were usually able to work with him with no combativeness or behaviors. Staff member U stated he only had a couple of days where he was agitated, and this was usually due to being really tired. Staff member U stated the family had found out about the restorative program, so that was when they had started working with resident #98. Staff member U stated they felt staff had a good dementia care approach, but that Everyone is in a rush in the morning. Staff member U stated it looked like it was a mix of disciplines that missed the PT/OT, including admissions telling the correct parties of the order, nursing assessing and realizing the order was needed, and PT/OT responding to the order.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to failed to ensure proper PPE was worn, clean technique was followed, a catheter bag was emptied timely, and catheter perineal care was completed correctly for an indwelling Foley catheter for 1 (#2), and the resident had multiple urinary tract infections in the prior year; and the facility failed to provide a physician ordered catheter change(s), failed to provide proper daily site assessments and a dressing change(s), and failed to empty the catheter drainage bag timely for a resident with a Suprapubic indwelling catheter, for 1 (#15). These deficient practices increased the risk of negative urinary outcomes for all residents receiving catheter services, out of 5 sampled residents for catheter use and care. Findings include:1. During an interview on 3/11/26 at 9:48 a.m., resident #2 stated he did not get catheter care often enough and suffered from facility acquired UTIs often. He stated he was lucky to get clean (catheter care) once a day, and nothing gets done unless you ask for it. Resident #2 stated he had gone septic from a few of his UTIs, and this had almost killed him. A request was made for all documentation for resident #2 regarding Foley care, appointments, and UTIs. The documentation provided showed resident #2 had the following UTIs in the past year: 4/16/25, 4/29/25, 5/11/25, 7/2/25, and 8/13/25. During an interview and observation on 3/11/26 at 9:55 a.m., staff member V stated a catheter bag should not be this full, but a staff member had called off this morning, and no one had emptied the catheter for #2. Staff member V stated call offs would happen four times a week. Resident #2's catheter bag was full, and the urine was backing up into the catheter tubing a few inches. During an observation on 3/11/26 at 10:12 a.m., staff member V did perineal care on resident #2, but it was incomplete as the penis was retracted into the surrounding tissue. The glans was not exposed for cleaning during the perineal care. When asked, staff member V stated they always retracted the surrounding tissue and then completed the task, which revealed a whitish buildup around the glans. 2. During an observation and interview on 3/10/26 at 10:56 a.m., resident #15 was lying in his bed in his room. He had a urinary drainage bag attached to his bedside. The catheter drainage bag had over 2000 ml of urine in the bag. Resident #15 stated he recently had a Suprapubic catheter placed by the urologist because he kept getting UTI's when he had a Foley catheter. He stated he thought the insertion site was healing fine, except he still had some pain at the insertion site when the staff cleaned the site or changed the dressing. He stated he could not remember when the catheter was last changed, when they last changed his dressing, and the resident could not remember when they last emptied his catheter drainage bag. He stated the staff only provided his care when they could get around to it. The resident then lifted his nightgown to show his suprapubic catheter site. The site was covered with a white gauze dressing, which was dated 3/9/26, with the initials of the staff member who last changed the dressing. a. Suprapubic Catheter Change Review of resident #15's Physician Orders, dated 12/13/25, showed, Change SP Catheter PRN or as indicated by MD. Change SP [every] month and prn, use 16 [French]/10cc per Urology. One time a day every 1 month(s) starting on the 1st for 1 day(s) for urinary retention related to Obstructive and Reflux uropathy. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Review of resident #15's Treatment Administration Record (TAR) for March 2026, showed the Suprapubic catheter was to be changed on 3/1/26. The TAR did not show the catheter change was completed on 3/1/26. A review of resident #15's EHR did not show documentation of the catheter change or a refusal for the catheter change on 3/1/26. Review of resident #15's Progress Note, dated 3/5/26, showed, [Complaints of] pain at Supra pubic site - Cath changed / sterile tech / orders (16f with 10cc balloon). (Less than) 400cc out – [tolerated] well - draining / gravity - call bell within reach. [sic] Review of resident #15's Progress Note, dated, 3/12/26, showed, Catheter not changed on 3/1/26 6pm-6am shift second to this LN involved in continuous close monitoring and care of another resident. Resident aware. Reported to AM nurse for follow up. [sic] During an interview on 3/11/26 at 11:12 a.m., staff member I stated resident #15's Suprapubic catheter should be changed monthly, but sometimes it needed to be changed more often since the resident had a lot of sediment in his urine, and it would often block the drainage tube. Staff member I stated he was not sure when the last time resident #15's Suprapubic catheter was changed or why it was not changed on 3/1/26. b. Missed Assessment and Dressing Change During an observation and interview on 3/11/26 at 11:00 a.m., staff member I performed site care for resident #15's Suprapubic insertion site. Staff member I removed the white gauze covering the resident's site. The gauze was dated 3/9/26, with the initials of the staff member who last changed the dressing. The resident's Suprapubic site was dimpled into his lower abdomen. The dimple where the catheter tube entered the resident's abdomen was pooled with a thick and chunky appearing drainage that was yellow and greenish in color. There was dried drainage on the tubing. Staff member I cleansed the site and attempted to remove some of the dried drainage from the tubing. Resident #15 started to raise his voice at the nurse stating, ouch, that hurts and used some expletives. Once staff member I finished cleansing the site, resident #15 quit yelling about the site hurting. Staff member I then placed a clean gauze over the site and left the resident's room. During an interview on 3/11/26 at 11:12 a.m., resident #15 stated he was having discomfort at the insertion site when staff member I was changing the dressing. He stated the site did not usually hurt, only when someone applied pressure or pushed on the area. During an interview on 3/11/26 at 11:15 a.m., staff member I could not explain why resident #15's catheter site was not assessed, or the dressing was not changed on 3/10/26. He stated if the resident had refused, there should be a note in his chart documenting the refusal. Review of resident #15's Physician Orders, dated 12/15/25, showed, Assess suprapubic catheter site [every] shift related to Obstructive and Reflux Uropathy. c. Emptying Catheter Drainage Bag During an observation and interview on 3/10/26 at 10:56 a.m., resident #15 was lying in his bed in his room. He had a urinary drainage bag attached to his bedside. The catheter drainage bag had over 2000 ml of urine in the bag. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During an observation on 3/10/26 at 11:28 a.m., resident #15's urinary catheter drainage bag was full of urine above the measurement line of 2000 ml on the bag. The urinary catheter bag showed to hold a maximum amount at 2000 ml of urine. Note: The average normal range for 24-hour urine volume is 800 to 2,000 milliliters per day.¹ During an observation on 3/10/26 at 3:27 p.m., resident #15's catheter drainage bag was completely full to the top of the bag and starting to regurgitate into the catheter tubing. Note: Failure to empty a catheter bag (which should be done when it is full) can lead to serious physical complications due to back pressure on the bladder and kidneys, as well as an increased risk of infection.² During an interview on 3/11/26 at 10:36 a.m., staff member J stated she would empty resident #15's catheter bag several times a day, or at least once during her shift. She stated she would usually empty the drainage bag at the end of her shift. She stated she documented the urinary output of the bag in the resident's chart. Staff member J stated she did not feel there were any barriers to emptying resident #15's catheter bag during her shift. During an interview on 3/11/26 at 10:36 a.m., staff member I stated the aides usually emptied a resident's urinary catheter bag at least once a shift. He stated they were to report any changes they observed to the nurse. Staff member I stated it could lead to infection and other urinary tract complications if the urinary drainage bag was completely full and not emptied regularly. Staff member I stated he was not aware of any concerns with emptying resident #15's urinary drainage bag. During an interview on 3/11/26 at 11:20 a.m., staff member B stated it was the expectation for staff to follow the provider's orders for catheter changes and site care. Staff should notify the provider if there is any concern regarding the catheter or the insertion site, such as swelling, pain, and drainage. She stated she was not sure why resident #15's catheter was not changed on 3/1/26, since there was no documentation in his chart for why it was not completed. Staff member B stated she also could not explain why resident #15's Suprapubic site care was not completed on 3/10/26. She stated there was nothing documented in the resident's chart regarding a refusal or rationale for why it was not changed. Staff member B stated staff were expected to empty catheter drainage bags when the bag was half to one third full, or as needed, and at least once a shift, and document the output in the resident's chart. Staff member B stated she was not aware of any concerns regarding resident #15 refusing care or any concerns regarding the management of his Suprapubic catheter. A review of the facility's policy and procedure titled, Catheter Care, with an initiation date of 4/11/25, showed: 1. Catheter care will be performed every shift and as needed by nursing personnel . 8. Empty drainage bags when bag is half-full or every 3 to 6 hours. For Suprapubic Catheters: 2. Inspect insertion site for redness, swelling, discharge, or signs of infection. 3. Using a clean cloth or gauze moistened with mild soap and water or facility-approved cleanser (or per orders), gently clean around the insertion site in a circular motion, starting closest to the catheter (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ a certified dietary manager or a full-time dietician to serve as the director of food and nutrition services. The deficient practice had the potential to affect all residents who received meals and nutritional services from the facility. The deficient practice increased the risk for food quality/safety concerns; resulted in inadequate oversight of food service operations; increased the potential for weight loss; resulted in residents eating less and feeling hungry (see F804.) Findings include:A request for the Dietary Managers Certification was submitted to the facility on 3/10/26 at 8:08 a.m. The facility was unable to provide appropriate certification for staff member M. The facility provided a copy of a ServSafe Certification dated 12/7/23 for staff member M.During an interview on 3/11/26 at 10:28 a.m., staff member M stated she did not have a current Certified Dietary Manager Certification. Staff member M stated she was currently enrolled in the training. Staff member M stated she was enrolled after the request for her certification was made the day before.During an interview on 3/11/26 at 11:45 a.m., staff member K stated she was employed by the facility full time. Staff member K stated she worked 35 to 40 hours a week in the facility. Staff member K stated she had worked for the facility for two weeks.During an interview on 3/11/26 at 12:20 p.m., staff member A stated staff member K is a full time employee. Staff member A stated the previous dietician was not employed full time. Staff member A stated he was not previously aware that a ServSafe Certification did not meet the requirement for a Certified Dietary Manager. Staff member A stated staff member M had been enrolled in the Certified Dietary Manager course as a result.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide palatable food (including appetizing food visually, taste wise, and with preferences) for 10 (#s 2, 8, 26, 27, 36, 50, 73, 74, 79 and 101) of 38 sampled residents. This deficient practice resulted in residents eating less, feeling hungry, a potential in weight loss, and resident #74 requesting to be discharged . Findings include:During an interview on 3/9/26 at 2:40 p.m., resident #36 stated the food is passable, but was sometimes cold by the time it was delivered to her in her room.During an interview on 3/9/26 at 2:47 p.m., resident #26 stated the food sucks. He stated the food had no good flavor, They don't cook it right, and they're not good cooks.During an interview with resident #2 and #79 on 3/9/26 at 3:12 p.m., resident #2 stated the food was terrible, and It's so bad. He stated many times he was unable to identify the food on his plate. He stated the food was unappetizing visually, but also after eating it as well. He stated one time he was served a burger with just the bun, no condiments or toppings. Resident #79 also stated he was served a burger with just the bun. Resident #79 stated he ate cereal often because he disliked the food so much. Resident #79 stated, You don't know what it is (when looking at it or after eating it). He stated he loved biscuits and gravy but by the time it was served to him the biscuits were soggy, and the food was cold. He said most food felt like the temperature of ice to him. He stated he had never seen any staff member take the temperature of his or his roommate's food before. Resident #79 stated the eggs served at the facility were also terrible. He stated he had personally asked the cook to make him over-easy eggs for breakfast, and they are hard by the time they are served or just burnt. Resident #79 stated, I'm always hungry here. Resident #79 stated he either was not served enough food or he would not eat what was served. Both resident #2 and #79 stated the food was always cold.During an interview on 3/9/26 at 3:59 p.m., resident #73 stated the food is pathetic at the facility. Resident #73 stated he never ate breakfast because he disliked the food so much.During an interview on 3/9/26 at 4:02 p.m., resident #74 stated the facility could improve with . better food. Man, the food is terrible. Resident #74 stated she could never eat the eggs at the facility. She stated the eggs were served as two big scoops of ice cream and had no taste. She stated she was served a pork chop and had to eat it with her fingers because it was too hard to cut. Resident #74 stated that one time she was served a plate full of cooked carrots, and stated, I thought, what in the world. I was just so shocked. She stated that day, the CNA had told her she was going to be surprised by what was served. Resident #74 stated she often was hungry (including the day she was only served cooked carrots). Resident #74 stated she was not served enough calorie-dense or filling foods, which contributed to her feeling hungry.During a return phone call with NF5 on 3/16/26 at 10:52 a.m., NF5 stated resident #74 was crying because she was served a plate full of cooked carrots and soup with tofu or ham and water. During an interview on 3/9/26 at 4:11 p.m., resident #50 stated the food that was served one night . was bad. Resident #50 stated it was onion and ham soup that was unappetizing visually and taste-wise.During an interview and observation on 3/10/26 at 9:32 a.m., resident #2 stated his eggs were super hard, and he was unable to dunk his bread in the yolk. When taking a fork, one yolk had a small bit of yolk left, but the majority of the three eggs were closer to a poached egg than an over-easy egg. Resident #79's eggs were burnt on the bottom. Both residents ate some of their breakfast but left the eggs. During an interview and observation on 3/10/26 at 9:36 a.m., resident #73 stated he disliked the scrambled eggs as they were a scoop of eggs, and he had not been served a piece of toast since he had been at the facility. He stated he was constantly served potatoes with gross gravy.During an observation and interview on 3/10/26 at 5:41 p.m., resident #11 was served a spinach salad with honey mustard dressing over the top of it. Resident #11 stated the facility always served salads with this same type of dressing, which no one seemed to like. Resident #11 stated he wished the facility would get more variety in the salad dressings instead of serving the same one over and over.During an interview and observation on 3/10/26 at 5:42 p.m., resident #27 held up a whole piece of spinach and stated, This looks like a weed (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in my garden. Resident #27 had placed some of the large pieces of spinach on the side of her plate. The salad only consisted of whole pieces of spinach and no other greens. And the salad was topped with tomatoes and hard-boiled eggs.During an interview and observation on 3/10/26 at 5:43 p.m., resident #101 stated the salad dressing was too sweet and gross. Resident #101 stated blue cheese salad dressing would taste really good on the salad served, but that was not an option. Resident #101's salad was barely touched, and he also had large pieces of spinach.During an interview on 3/11/26 at 9:28 a.m., resident #8 stated the food could be way better, and the food isn't even worth eating.Review of a facility policy, titled Food Preparation Guidelines, dated 4/11/25, showed: . 3. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: . d. Addressing resident complaints about foods/drinks.

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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. Based on observation and interview, the facility failed to store food in a safe, sanitary manner; failed to maintain cooler temperatures within a safe range; and failed to maintain cleanliness of the kitchen and food preparation/storage areas. The deficient practices caused increased risk for foodborne illness for all residents receiving food from the dietary department. Findings include:During an observation on 3/9/26 at 1:19 p.m., the following concerns were observed:- Ground [NAME] with an expiration date of 3/21/25- Ground Sage with an expiration date of 8/17/24- A box of foam containers was sitting directly on the floor- Two paper towels were noted on the floor beside a garbage can to the right of the handwashing station in the kitchen. The garbage can was full and overflowing- Stovetop burners had a thick black buildup on them- A slice of white bread was observed on the kitchen floor- Crumbs, particles of food, dirt and grease were observed on the shelves and boxes where pan liners and foil were stored- Food and garbage was observed on the floor in the walk-in-freezerDuring an observation on 3/12/26 at 9:12 a.m., the following concerns were observed:- Two mayonnaise packets on the floor in the dry storage area- Dirt and food particles on the floor of the walk-in-freezer- Dirt and food particles were observed on the floor outside the door to the walk-in-freezer- A wrapper, paper, and food particles were observed on the floor inside the walk-in-cooler- A pitcher containing an orange liquid was on a cart inside the walk-in-cooler. There was no date on the pitcherDuring an interview on 3/9/26 at 1:56 p.m., staff member M stated the counters and floors in the kitchen were cleaned daily. Staff member M stated the burners on the stove were cleaned every Saturday. Staff member M stated the shelves where pan liners and foil were kept were obviously not cleaned often enough. Staff member M stated temperatures were recorded twice a day every day. Staff member M stated cold food should be stored at or below 41 degrees Fahrenheit. Staff member M stated the walk-in-cooler was getting old and sometimes temperatures were noted above 41 degrees Fahrenheit. Staff member M stated when this occurred staff should wait 15 minutes and if the temperature was still out of range, maintenance should be notified to adjust the cooler setting. Staff member M stated there were no follow-up temperatures recorded to show adjustments.A review of temperature logs for the facilities walk-in-cooler showed:- March 2026: Temperatures were recorded above 41 degrees Fahrenheit nine times with no documented follow up. Temperatures were not recorded four times- February 2026: Temperatures were recorded above 41 degrees Fahrenheit nine times with no documented follow up. Temperatures were not recorded seven times- January 2026: Temperatures were recorded above 41 degrees Fahrenheit 18 times with no documented follow up. Temperatures were not recorded 21 timesDuring an interview on 3/12/26 at 8:59 a.m., staff member A stated he would try to do rounds to ensure the cleanliness of the kitchen, check food temperature logs weekly. He stated he would point out areas which needed to be cleaned and would try to follow back later to ensure the area was cleaned. A review of a facility policy titled, Food Safety Requirements, implemented on 4/11/25, showed: Policy:. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.A review of a facility policy titled Sanitation Inspection, last reviewed on 2/27/26, showed: Policy Explanation and Compliance Guidelines:1. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. 4. Sanitation inspections will be conducted in the following manner:a. Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher temperatures daily. [sic]

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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. Based on observation, interview, and record review, the facility failed to maintain a sanitary environment, by not maintaining clean resident rooms and resident bathrooms, for 6 (#s 3, 7, 24, 35, 57, and 80) of 41 sampled residents; and failed to keep the community bathing/shower room on the A and B hall clean. Findings include:During an interview on 3/9/26 at 3:42 p.m., NF2 stated the resident rooms, resident bathrooms, and the community bath/shower rooms had been dirty.During an observation on 3/10/26 at 8:07 a.m., the bathroom floor in resident room B10 had dried, light black spots on various places on the floor.During an observation on 3/10/26 at 8:08 a.m., the bathroom floor in resident room B7 had a dried, light brownish/black stain covering over half of the one-foot square tile under the toilet and when wiped with a wet, white paper towel, the paper towel became stained with a brownish/yellow stain with black specks and hair.During an observation on 3/10/26 at 8:12 a.m., the community bath/shower room for the A and B halls contained two showers and was noted to have a light gray/black stain about 18 inches in diameter around the drain just outside the shower closest to the entrance door. The shower drain, for that shower, had a brownish stain around one side of the drain and the drain was partially occluded with hair. The second shower was noted to have the hand-held shower head lying on the floor of the shower next to the shower stool.During an observation on 3/10/26 at 10:36 a.m., the floor in room B9 had multiple dried drip stains running from the bathroom to the bed on the left side of the room as viewed from the door.During an observation on 3/11/26 at 8:31 a.m., the community bath/shower room for the A and B halls was noted to have brownish/black staining randomly across the linoleum floor just outside the showers. When the floor was wiped with a wet, white tissue, the tissue became stained brownish/black.During an observation on 3/11/26 at 8:34 a.m., the floor in room B9 still had multiple dried drip stains running from the bathroom to the bed on the left side of the room as viewed from the door.During an observation on 3/11/26 at 8:35 a.m., the bathroom floor in resident room B7 still had a dried, light brownish/black stain covering over half of the one-foot square tile under the toilet.During an interview on 3/11/26 at 8:37 a.m., staff member O stated that when the memory care unit got a housekeeper, the memory care unit would be relatively clean. Staff member O stated the memory care unit had gone up to a week sometimes without any housekeepers. Staff member O further stated the aides and herself had tried to keep up with the cleaning when there were no housekeepers. During an interview on 3/11/26 at 8:50 a.m., staff member H stated there was a housekeeper assigned to clean resident rooms on each hall every day, Monday through Friday. Staff member H further stated the CNA's that gave showers would clean up after each resident shower and housekeeping staff would do a deeper clean of the shower rooms two times a week.During an observation and interview on 3/11/26 at 8:53 a.m., while observing the bathing/shower room for the A and B halls, staff member H stated the shower room doesn't look like it had been cleaned.During an observation and interview on 3/11/26 at 8:55 a.m., while observing the bathroom for resident room B7, and the floor in resident room B9, staff member H stated that it had not met her expectation. During an interview on 3/12/26 at 7:54 a.m., staff member B stated staff member A oversees the housekeeping and the shower rooms should have been cleaned by the CNA after each resident was showered.During an interview on 3/12/26 at 8:59 a.m., staff member A stated he completed Guardian Angel Rounds where he would look in rooms and if they needed to be cleaned he would notify housekeeping. He stated all managers in general were looking at certain rooms to ensure the cleanliness of those rooms. He stated there were Swiffer Sweepers available at all the nurses' stations so staff could clean up any messes or spills they seen if housekeeping was not immediately available. He stated If there were areas which needed to be cleaned more readily there was a WhatsApp group chat nurses could utilize to notify if there was a dirty area which needed to be cleaned as well as the paging system if needed.A review of a facility policy titled, Routine Cleaning and Disinfection, with an implemented date of 4/11/25, showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy:It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.Definitions:'Cleaning' refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products.Policy Explanation and GuidanceI. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have the required enhanced barrier precaution (EBP) signage posted for residents who required EBP for cares for 2 (#s 15 and 82); failed to ensure staff adhered to EBP protocols for personal protective equipment (PPE) while providing catheter care for a Suprapubic catheter for 1 (#15); failed to ensure proper perineal care was completed, clean technique used, and enhanced barrier precautions were followed when emptying a foley catheter bag for 1 (#2); and failed to ensure hand sanitizer was available to prevent the spread of infection for 4 (#s 54, 71, 73, and 74) of 38 sampled residents. These deficient practices increased the risk of facility acquired UTI's, and the transmission of microorganisms from resident to resident. Findings include: 1. No EBP Signage a. During an observation and interview on 3/10/26 at 9:35 a.m., on the outside of the door for resident #82's room was a hanging PPE caddy. There was no signage on the door to show what type of precautions were to be taken. Staff member I stated resident #82 was on EBP because he had an upper right chest port for dialysis. Staff member I stated he would need to get a sign to place on the resident's door. b. During an observation and interview on 3/10/26 at 11:36 a.m., on the outside of the door of resident #15's room was a hanging PPE caddy. There was no signage on the door to show what type of precautions were to be taken. Staff member I stated resident #15 was on EBP related to his indwelling catheter. Staff member I then left to get a sign to place on the door. 2. No EBP Used During an observation and interview on 3/11/26 at 11:00 a.m., staff member I performed catheter care for resident #15's Suprapubic catheter. Staff member I did not don the appropriate PPE for EBP prior to performing the catheter site care. Staff member I stated he knew he needed to put on the PPE for the EBP while providing the catheter care but did not expect to be changing the dressing for the resident at that time. He stated he could have stopped and put on the appropriate PPE. Review of resident #15's Order Summary, dated 12/8/24, showed, Nursing Order Enhanced Barrier Precautions: PPE required for high or direct care resident contact activities [due to] indwelling catheter. During an interview on 3/11/26 at 11:20 a.m., staff member B stated it was the expectation for the proper signage to be placed on the door next to the PPE caddy so staff and visitors would know what PPE to put on before entering a residents' room or providing care if they had infecton control precautions in place. Staff member B stated staff were expected to put on and use the appropriate PPE for EBP when providing catheter care for residents with any type of indwelling device. 3. During an interview and observation on 3/9/26 at 2:35 p.m., the hand sanitizer located inside of resident #54's room did not work when pushed, even though the hand sanitizer was in the container. Resident #54 stated, It's been a while since the hand sanitizer worked in her room. During an observation and interview on 3/9/26 at 3:48 p.m., the hand sanitizer located in resident #71's room was out of hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/9/26 at 4:02 p.m., resident #74's hand sanitizer did not work. During an observation on 3/10/26 at 1:28 p.m., resident #73's hand sanitizer did not work. During an observation on 3/10/26 at 5:02 p.m., resident #73's hand sanitizer did not work. During an observation on 3/11/26 at 7:33 a.m., resident #73's hand sanitizer did not work. During an observation on 3/11/26 9:39 a.m., resident #73's hand sanitizer did not work. During an observation on 3/11/26 2:03 p.m., resident #73's hand sanitizer did not work. During an observation and interview on 3/11/26 at 5:21 p.m., staff member V tried to use the hand sanitizers in residents #s 54, 71, and 73 rooms. Staff member V stated they did not know these were empty as they always washed their hands every time when entering and when leaving a resident's room. Staff member V stated they felt three rooms without working hand sanitizer was a large number. During the catheter care and catheter emptying observations, staff member V failed to wash her hands or use hand sanitizer prior to and after the tasks (on 3/11/26 at 9:55 a.m. and 10:12 a.m.). 4. During an interview on 3/11/26 at 9:48 a.m., resident #2 stated he did not get catheter care often enough and suffered from facility-acquired UTIs often. He stated he was lucky to get clean (catheter care) once a day, and nothing gets done unless you ask for it. Resident #2 stated he had gone septic from a few of his UTIs and this had almost killed him. A request was made for resident #2's Foley care, appointments, and UTI documentation. The documentation provided showed resident #2 had the following UTIs in the past year: 4/16/25, 4/29/25, 5/11/25, 7/2/25, and 8/13/25. During an interview and observation on 3/11/26 at 9:55 a.m., staff member V stated resident #2's catheter bag should not be located on the ground because it was not sanitary. Staff member V moved the catheter bag from the ground and into the basin that was located far underneath the bed. Resident #2's catheter bag was completely full, and the urine was backing up into the catheter tubing a few inches. Staff member V stated a catheter bag should not be this full, but a staff member had called off this morning, and no one had emptied the catheter. Staff member V stated call offs would happen four times a week. Staff member V grabbed an empty basin and bent down to drain the urine from resident #2's catheter bag (with only gloves on). When asked about the PPE hanging on the door, staff member V stood back up and put a gown on (while using the same gloves). Staff member V stated they felt the PPE on the door was only good for collecting dust and other junk in the facility. Staff member V emptied 825 ml then 650 ml, then used an alcohol pad to clean the drainage valve. During an observation on 3/11/26 at 10:12 a.m., staff member V did perineal care on resident #2, but it was incomplete as the penis was retracted into the surrounding tissue. The glans was not exposed for cleaning during the perineal care. When asked, staff member V stated they always retracted the surrounding tissue and then completed the task. When staff member V retracted the surrounding tissue, there had been a whitish buildup around the glans. Review of resident #2's physician order, dated 8/15/25, showed: Enhanced barrier precautions: PPE required for high-contact direct care activities r/t indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/26 at 9:16 a.m., staff member D stated staff were educated on Enhanced Barrier Precautions upon hire, and annually thereafter. Staff member D stated gloves and gowns should be worn with high contact cares, such as catheter care. Staff member D further stated that when staff were providing care to a resident who was on EBP, staff should change gloves after removing a dirty dressing and put new gloves on before applying a clean dressing.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review, the facility failed to honor a POA's (Power of Attorney) wishes with regard to treatment for 1 (#84) of 41 sampled residents. This deficient practice resulted in the POA not being informed of resident #84's condition or treatment, the resident continuing to receive a psychotropic medication without the POA's knowledge for approximately six months, and the resident receiving the psychotropic medication for approximately two months after the POA requested it to be stopped. Findings include: During an interview on 3/9/26 at 4:02 p.m., NF1 stated that the facility had not contacted her for a care conference for resident #84, since the last care conference in August 2025, and she had not heard from the facility since then. NF1 stated during the care conference, in August 2025, the facility had informed her that due to resident #84's depression, Ativan had been prescribed and was being administered to resident #84 since February 2025. NF1 further stated that she never gave consent for the Ativan and she informed them during the August care conference, she wanted the facility to stop administering Ativan to resident #84. A review of resident #84's Clinical Resident Profile in the facility's EHR showed [NF1] was the Responsible Party, POA, Care Conference Person, Emergency Contact #1, . Responsible Care. [sic]A review of a medication order for resident #84 in the facility's EHR, dated 2/12/25, showed, Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 1 tablet by mouth every 24 hours as needed for Aggression Give 1 hour prior to bath/shower. [sic]A review of a medication order for resident #84 in the facility's EHR, dated 2/16/25, showed, Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 1 tablet by mouth every 24 hours as needed for Aggression with showering. Give 1 hour prior to bath/shower only 1-2x/week. [sic]A review of a medication order for resident #84 in the facility's EHR, dated 2/26/25, showed, Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 1 mg by mouth as needed for Aggression with showering. Give 1 hour prior to bath/shower only 1-2 times per week, 1 hour prior to bath or shower. [sic]A review of a medication order for resident #84 in the facility's EHR, dated 5/21/25, showed, Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 0.5 mg by mouth two times a day for Anxiety, agitation. [sic]A review of a medication order for resident #84 in the facility's EHR, dated 6/22/25, showed, Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 1 mg by mouth as needed for Aggression with showering. Give 1 hour prior to bath/shower for 90 days 1-2 times per week, 1 hour prior to bath or shower. [sic]A review of resident #84's MAR for the months of February to April 2025, showed, Ativan was administered seven times PRN from 2/12/25 through 4/3/25.A review of resident #84's MAR's for months of June to October 2025, showed, Ativan was administered to resident #84 two times a day, every day from 6/1/25 to 10/29/25.A review of a facility document titled, Care Conference Summary Form, dated 8/8/25, showed, List of names and titles (as applicable) of the people who participated in the meeting: . [NF1] via phone. Medication Review, . Went over medications. [NF1] wasn't aware of Ativan.During an interview on 3/11/26 at 9:17 a.m., staff member E stated the facility never informed NF1 that resident #84 was taking Ativan. NF1 found out that resident #84 was taking Ativan during the care conference in August, and she hung up before the care conference was completed.During an interview on 3/11/26 at 10:45 a.m., NF1 stated she was contacted by a nurse in October 2025 for an updated consent for Ativan, That's when I found out they were still giving [Resident #84] Ativan after I told them to stop in August 2025.A review of a facility document titled, Resident Rights, with a date of 7/7/23, showed: (b) Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law .(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the resident representative.(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.(c) Planning and implementing (continued on next page)

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	275025	A. Building B. Wing	03/12/2026

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care. The resident has the right to be informed of, and participate in, his or her treatment, including:(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.(iii) The right to be informed, in advance, of changes to the plan of care.(6) The right to request, refuse, and/or discontinue treatment, . [sic]

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to consult and receive a representative's permission to order and administer a psychotropic medication for a resident on the memory care unit, for 1 (#84) of 41 residents. This deficient practice resulted in the resident representative not being informed in advance or being allowed to make treatment decisions for the resident's care. Findings include:A review of resident #84's Clinical Resident Profile in the facility's EHR showed [NF1] was the Responsible Party, POA, Care Conference Person, Emergency Contact #1, . Responsible Care. [sic]During an interview on 3/9/26 at 4:02 p.m., NF1 stated she found out the facility was administering Ativan to [Resident #84] for six months, without her consent.During an interview on 3/11/26 at 9:17 a.m., staff member E stated NF1 had not been informed that [Resident #84] was receiving Ativan. Staff member E further stated that NF1 was on the phone during the care conference for [Resident #84] in August 2025 and hung up when she was told [Resident #84] was prescribed Ativan without her knowledge.During an interview on 3/11/26 at 10:45 a.m., NF1 stated she received a phone call from a nurse at the facility, sometime in October 2025, asking for a verbal consent to continue administering Ativan to resident #84. NF1 further stated that's when I found out they were still giving her Ativan, after I told them to stop in August 2025.A review of a facility document titled, Resident Rights, with a date of 7/7/23, showed: . (4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.(6) The right to request, refuse, and/or discontinue treatment, . [sic]A review of a facility policy titled, Care Planning-Resident Participation, with a date implemented of 5/13/25, showed: Policy:This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care).Policy Explanation and Compliance Guidelines: .3. The facility will notify the resident and/or resident representative, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care, as well as changes to the plan of care.4. The facility will encourage and assist the resident and/or resident representative to participate in choosing care and treatment options including:a. Initial decisions about treatmentb. Decisions about changesc. The right to refuse treatment .

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interview and record review the facility failed to schedule timely care conferences with the POA (Power of Attorney) for a resident who resides on the memory care unit, for 1 (#84) of 41 sampled residents. Findings include:During an interview on 3/9/26 at 4:02 p.m., NF1 stated she had not been notified or involved in a care conference for [Resident #84] since August 2025.During an interview on 3/10/26 at 2:22 p.m., staff member E stated she scheduled care conferences within 48 hours of admission and then annually. Staff member E further stated there was no documentation of invitations to care conferences for NF1.During an interview on 3/11/26 at 9:05 a.m., staff member E stated she was unaware that care conferences for residents was supposed to be conducted quarterly and had only been having them annually. Staff member E stated she was unaware she was supposed to invite the POA to the care conference. Staff member E further stated she did not know a care conference should have been held if a resident had a change of condition.During an interview on 3/11/26 at 10:45 a.m., NF1 stated the prior management of the facility before it was [Facility name] had conducted care conferences with her for [Resident #84] on a quarterly basis.During an interview on 3/12/26 at 7:54 a.m., staff member B stated care conferences for residents should have been done on admission, then quarterly and when there was a change in the resident's condition. A review of resident #84's medical record showed, two care conferences in the last 12 months, one on 3/12/25 and the other on 8/8/25.A review of a facility policy titled, Care Planning-Resident Participation, with an implemented date of 5/13/25, showed: Policy:This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care).Policy Explanation and Compliance Guidelines: .8. The facility will honor requests for care plan meetings and acknowledge requests for revisions to the person-centered plan of care.9. The facility will honor the resident's right to participate in establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit an initial incident report for an allegation of neglect to the State Survey Agency, for 1 (#11) of 38 sampled residents. The resident did not receive the necessary care and services related to a nephrostomy tube and the tube being dislodged during care, which was later identified to be an accident. Findings include:Review of resident #11's progress note, created on 2/23/26 at 4:46 p.m., showed: Secure Message:[DATE] . The tube is out 5 inches from the stitches; no urine output. resident stated tube was pulled out by a CNA on Wed or Thur. and stopped draining urine today. [sic]During an interview on 3/11/26 at 3:09 p.m., staff member C stated he was aware of the allegation that a CNA had caused resident #11's nephrostomy tube to become dislodged. Staff member C stated he did not report this to staff member A. Staff member C stated it should have been reported to staff member A. Staff member C stated that's not my job.During an interview on 3/11/26 at 3:15 p.m., staff member A and staff member B stated the facility did not report the allegation that a CNA had caused resident #11's nephrostomy tube to become dislodged to the State Survey Agency. Staff member A stated the Interdisciplinary Team had reviewed it at the time and did not feel it was neglect.A review of resident #11's progress note, with an effective date of 3/11/26 at 3:29 p.m., showed: NHA spoke with resident on the incident with CNA where his nephrostomy tube had come out. He did not feel it was an abusive or neglectful act.During an interview on 3/11/26 at 4:30 p.m., staff member A stated his conversation with resident #11 about the nephrostomy tube being dislodged, occurred on 3/11/26, not at the time of the allegation.A review of a facility policy titled, Abuse, Neglect and Exploitation, implemented 4/11/25, showed: . Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The components of the facility abuse prohibition plan are discussed herein:. VII. Reporting/Response. A. The facility will have written procedures that include:1. Reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. [sic]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify and investigate an allegation of potential neglect of care for 1 (#11) of 38 sampled residents. The allegation was later found to be an accident, but the reporting timeline was not met for an allegation of neglect, and the investigation was not immediately initiated for neglect of care, in an attempt to rule out neglect of care. Findings include:A review of resident #11's progress note, created on 2/23/26 at 4:46 p.m., showed: Secure Message:[DATE]Rachael Garrey. The tube is out 5 inches from the stitches; no urine output. resident stated tube was pulled out by a CNA on Wed or Thur. and stopped draining urine today. [sic]During an interview on 3/11/26 at 3:15 p.m., Staff member A stated the facility had not investigated the allegation to rule out neglect because the IDT did not feel that it was a reportable incident.A review of resident #11's progress note, with an effective date of 3/11/26 at 3:29 p.m., showed: NHA spoke with resident on the incident with CAN where his nephrostomy tube had come out. He did not feel it was an abusive or neglectful act.During an interview on 3/11/26 at 4:30 p.m., staff member A stated his conversation with resident #11 about the nephrostomy tube being dislodged, occurred on 3/11/26, not at the time of the allegation.A review of a facility policy titled, Abuse, Neglect and Exploitation, implemented 4/11/25, showed: . Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The components of the facility abuse prohibition plan are discussed herein:. V. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. [sic]

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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 implement safe interventions for swallowing medications and food for 1 (#73) of 38 sampled residents. This deficient practice resulted in resident #73 feeling rushed when taking his medications, coughing on the medications, and potentially vomiting. Findings include:During an interview and observation on 3/10/26 at 9:36 a.m., resident #73 stated only the physical therapist helped him sit up in the day to eat, but they would not visit him until early afternoon. He stated he had already eaten breakfast. Resident #73 was lying flat on his back with his head kinked forward. He stated he would often choke or throw up from taking the medications if a nurse rushed him, but had no problem swallowing food. He stated he swallowed the medications better at home because he had been sitting up in a chair before taking the pills.During an interview and observation on 3/10/26 at 9:51 a.m., resident #73 was about to be given his morning medications, and he asked staff member X, Can you adjust my head, so I don't choke? Resident #73 had been lying down with his head kinked forward. Staff member X had pushed the button to move the head of the bed of resident #73 up, but the movement was too quick, and resident #73 winced and asked to be moved back down to his original position. Staff member X asked if the new position was adequate, and resident #73 stated, I guess. Staff member X never tried to reposition resident #73 again or offer any education about swallowing with his head of the bed at a 30-degree angle. Staff member X gave a medication with a lot of pudding. Resident #73 chewed on the pudding for some time, swallowed, then coughed and spat out a bit of the pudding, which landed on his chest. Resident #73 stated he was able to swallow the medication. Resident #73 stated he never had a problem taking all of his medications altogether at home when sitting up.Review of resident #73's Care Plan, with an initiation date of 12/18/25, failed to show resident #73's need to be sat up during meals and during medication administration to prevent the risk of choking. This failure increased the resident's risk for choking on meals or medications each day or opportunity to consume them.Review of a speech therapy note, dated 2/12/26, showed: . Position during eval . posture impacts function, is modifiable with intervention .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to independently carry out activities of daily living (ADL) for self-grooming and showering was provided a regular shower and the removal of female facial hair for 1 (#6) of 4 sampled residents for ADL services. Findings include:During an observation and interview on 3/9/26 at 3:49 p.m., resident #6 was lying in her bed on her back, with a sheet covering her lower body. She had numerous sporadic gray chin and neck hairs, which were approximately 1 to 1.5 inches long. When asked if the resident preferred to have her facial hair removed, the resident nodded her head yes, as she stated, Yes. When asked if she needed help with shaving her face, the resident nodded and said, Yes, please. The resident had a moderate amount of dried white scaly and moist yellow eye rheum in both eyes. She had a slight musty odor emanating from her person. During an observation on 3/10/26 at 11:20 a.m., resident #6 was sitting in the common day room across from the E-Hall nurses' station. She continued to have numerous sporadic gray chin and neck hairs, which were approximately 1 to 1.5 inches long. During an observation on 3/10/26 at 5:01 p.m., resident #6 was sitting in her wheelchair and was at a table in a full communal dining hall with other residents and visitors. The resident continued to have the same numerous sporadic gray chin and neck hairs as observed previously. During an observation on 3/11/26 at 10:36 a.m., resident #6 was sitting in her wheelchair in front of the E-Hall nurses' station. Staff member I was assessing the resident's oxygen level. While waiting for the oxygen meter to register, staff member I leaned towards resident #6 and ran his finger across the resident's chin and neck hair, stating, We need to cut back your chin hairs.During an interview on 3/11/26 at 10:36 a.m., staff member J stated resident #6 usually had a shower once a week, and facial hair would be removed during the shower. Staff member J stated the resident did not typically refuse her showers, but if she did, they would reapproach her later and try again, or try again on another day. She stated if a resident refused a shower, they completed a shower refusal form. During an interview on 3/11/26 at 11:20 a.m., staff member B stated resident showers were provided weekly, and/or per the resident's preference. Preferences would be documented in the resident's care plan. She stated if a resident refused a shower, the staff were to attempt to reapproach the resident at a different time and try again. If the resident did not wish to reschedule the shower, the staff were to complete a shower refusal form and chart the refusal in the resident's medical chart. Staff member B stated that female chin hair removal would be dependent upon the resident's wishes.Review of resident #6's Care Plan, with a revision date of 4/1/24, showed a Focus of: Needs assistance with my ADL's for completion and hygiene. Ability limited by decreased shoulder ROM and fatigue. My care, and acceptance of care, may be affected by my diseases including psychosis and borderline personality disorder. With interventions to include: - Personal Hygiene/Grooming: requires partial/moderate to substantial/dependent assist of one staff. Encourage hair care by staff every morning. When I refuse, remind me of potential risk and positive outcome if I follow through with the task.- I prefer to shower weekly. I need assist of two for my showers.- If I refuse bath/bathing, report to charge nurse. Charge nurse to offer me alternative bathing, for example: bed bath, tub bath, shower. If I continue to refuse after attempt by charge nurse, report to DON and/or Administrator.Review of resident #6's shower/bathing log showed the resident was provided a bath on 3/1/26 at 5:59 p.m., and 3/11/26 at 5:59 p.m. A review of refusals for resident #6 did not show that any refusals were documented for March 2026.Review of resident #6's Nurse Progress Note, dated 3/11/26 at 6:31 p.m., showed, Resident had assistance to complete showering and personal hygiene, including the removal of her facial hair per her request. Resident expressed gratitude for the completion and tolerated process well. A review of the facility's policy and procedure titled, Activities of Daily Living, with an implementation date of 4/11/25, showed, The facility will. ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide the necessary care and services (including preferences, goals, and standards of care) to meet the resident's physical, mental, and psychosocial needs for 1 (#74) of 38 sampled residents. This deficient practice resulted in resident #74 feeling uncared for, crying about the food (or lack of) served to her, NF5 upset about the care provided to resident #74, and resident #74 requesting to be discharged from the facility. Findings include:During an interview on 3/9/26 at 4:02 p.m., resident #74 stated the facility could improve the food as it was . terrible. Resident #74 stated she could never eat the eggs at the facility. She stated the eggs were served as two big scoops of ice cream and had no taste. She stated she was served a pork chop that she had to eat with her fingers, and was once served a plate full of cooked carrots and no other items on the tray other than soup. Resident #74 stated she was often hungry at the facility, and she was not served enough calorie-dense or filling foods. She stated she did not like being at the facility, and NF5 had talked to staff members about their concerns many times.During an interview on 3/11/26 at 8:54 a.m., staff member E stated, I didn't know why she was discharging. Staff member E stated they now knew the reason why resident #74 wanted to discharge, but staff member E did not want to put in a progress note because it was going to sound bad. Staff member E stated the floor staff had been aware of resident #74 and the family's concerns, but stated nothing had been done. Staff member E stated her coworker needed more education as they had never told staff member E that resident #74 wanted to be discharged from the facility. Staff member E stated NF5 had called Monday morning (3/9/26) and had said she wanted to be discharged , but did not tell staff member E why she was being discharged . Staff member E stated NF5 stated, She said over the weekend, she was done, because resident #74 had been served a plate full of carrots and watery soup that consisted of either pieces of ham or tofu. Staff member E stated resident #74 had been crying because of what she was served. Staff member E showed the survey team a picture of this meal and stated, That looks wretched. Staff member E stated we get a lot of dietary complaints, and the administration just keeps doing PIPs (Performance Improvement Plan) or POCs (Plan of Correction). Staff member E stated resident #74's feet were swollen; her blood sugar was over 400 for three days because the therapeutic diets were not followed. Staff member E stated the facility was supposed to be their home.During a return phone call with NF5 on 3/16/26 at 10:52 a.m., NF5 stated resident #74 was crying because of the poor care she received, and the plate full of carrots was the last straw. Please see F804 for more dietary details.Review of resident #74's Care Plan, initiated 3/4/26, showed: . is at risk for alteration in nutritional status r/t inadequate protein intake and inconsistent carbohydrate distribution with increased demands for wound healing . chronic non-healing LLE wound and reports confusion regarding DM lifestyle management .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide a resident with necessary respiratory care and services in accordance with professional standards of practice and physician orders and failed to ensure a portable oxygen tank was replaced when the metered volume was empty for 1 (#6) of 4 residents sampled for oxygen therapy. This deficient practice increased the risk of negative outcomes related to hypercapnia (a condition characterized by abnormally high levels of carbon dioxide in the blood, typically caused by hypoventilation, chronic lung diseases, like COPD, or breathing issues resulting in confusion, fatigue, and shortness of breath). Findings include:During an observation and interview on 3/9/26 at 3:49 p.m., resident #6 was laying on her back turned slightly on her right side. The head of the bed was in the lowest position and was not elevated. There was an oxygen concentrator next to her bed. The oxygen concentrator was turned off, and there was no oxygen tubing attached to the oxygen concentrator. Resident #6 was not wearing any oxygen while in bed. When asked questions, the resident would respond with simple short answers but ended her answers with I am afraid. Resident #6 was not able to elaborate about what she was afraid of.During an observation on 3/9/26 at 5:00 p.m., resident #6 was laying in bed, with the head of the bed in the lowest position. The oxygen concentrator was off and there was no oxygen tubing connected to the concentrator. The resident was not wearing oxygen. Review of resident #6's Physician Hospital Discharge Summary and Order, dated 12/6/25, showed, Orders.Assessment and Plan:(1) Encephalopathy: Status: Acute resolved. Patient back to baseline mental status, level of function. Suspect metabolic encephalopathy in the setting of acute infection and hypoxia - was found without her oxygen on at SNF prior to admission and O2 sats in the 70s the morning of admission. Head CT negative for acute findings. She has had several previous admissions with similar presentation. ABG with mild hypercapnia to 53, though this appears chronic for her.(3) Chronic hypoxic respiratory failure: Status: Chronic Patient remains stable on baseline 1.5 L NC. Told patient she needs to keep her oxygen on at all times and if she feels short of breath needs to let nurse know at skilled nursing facility.(4) COPD (chronic obstructive pulmonary disease): No current evidence of exacerbation, remains stable on baseline O2.Review of resident #6's Facility Documented Physician Orders, with a start date of 12/29/24, showed, Continuous Oxygen at 2 LPM per nasal cannula. May titrate prn supplemental Oxygen from 1-4 L/min via nasal cannula prn for dyspnea to keep O2 saturations [greater than] 88 [percent]. May use portable tank or concentrator. Every shift related to Chronic Obstructive Pulmonary Disease and as needed for Hypoxia.Review of resident #6's Care Plan, with a revision date of 6/26/25, showed, [Resident #6] has oxygen therapy. The resident will have no signs or symptoms of poor oxygen absorption through the review date. Interventions:- Continuous Oxygen at 2 LPM per nasal cannula. May titrate prn supplemental.- Oxygen from 1-4 [liters per minute] via nasal cannula prn for dyspnea to keep O2 saturations [greater than] 88 [percent] May use portable tank or concentrator.- Head of Bed Elevation is needed due to shortness of breath.During an observation on 3/10/26 at 3:27p.m., resident #6 was sitting in her wheelchair in the day room next to the E-Hall nurses' station. She was wearing oxygen via a nasal canula that was attached to a portable oxygen tank on the back of her wheelchair. The oxygen was set at 1.5 liters of oxygen, but the metered volume on the oxygen tank showed the oxygen was empty.During an observation on 3/11/26 at 9:10 a.m., resident #6 was asleep in her wheelchair which was positioned in front of the E-Hall nurses' station. The resident was wearing oxygen via a nasal canula which was attached to an oxygen tank on the back of her wheelchair. The oxygen was set at 1.5 liters continuously.During an interview on 3/11/26 at 10:36 a.m., staff member J stated the resident should be on two liters of continuous oxygen via a nasal canula. Staff member J stated resident #6 could go a little while without the oxygen, but her oxygen levels would begin to drop without having the oxygen. She stated when the resident was in bed she should be wearing oxygen from the oxygen concentrator that was next to her bed and when she was up in the wheelchair she would use the oxygen from the tank on the back of (continued on next page)

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	03/12/2026

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her wheelchair. Staff member J stated she was not aware if resident #6 needed to be positioned in bed with the head of the bed raised.During an interview and observation on 3/11/26 at 10:36 a.m., staff member I stated resident #6 could go for a little while without oxygen, but her oxygen levels would drop into the low 70's without continual oxygen. Staff member I stated he usually set resident #6's oxygen setting at two liters continuous. Staff member I stated if he set her oxygen at two liters, that would usually keep the resident above 88 percent oxygen saturation. He stated if the resident did not have her oxygen on, and you were to check her oxygen levels after approximately 30 minutes, her oxygen saturations would be in the 70's or 80's. Staff member I stated if resident #6's oxygen was low; she usually became tired and would start having increased confusion and some behaviors. Staff member I stated he usually elevated the resident's head of her bed but stated she did not need it to be elevated. Staff member I checked resident #6's oxygen setting, stating it was currently set at 1.5 liters of oxygen. He then obtained a pulse oximetry reading of resident #6's oxygen saturation level, which showed the resident was at 94 percent blood oxygen. Staff member I then turned resident #6's oxygen dose down to one liter of oxygen.During an interview on 3/11/26 at 11:20 a.m., staff member B stated it was the expectation for staff to follow the orders for oxygen administration. She stated when a resident was on continuous oxygen, they should have an oxygen concentrator at bedside to administer oxygen while the resident was in their room or in bed. She stated staff should be monitoring residents oxygen tanks while rounding to ensure the oxygen was set to the correct amount and to ensure the oxygen canister was not empty.During an observation and interview on 3/12/26 at 9:39 a.m., resident #6 was asleep in her wheelchair in the day room across from the E-Hall nurses' station. The resident's nasal canula and tubing were out of her nose and resting over her shoulder behind the wheelchair. The oxygen was set at one liter of oxygen. The metered volume on the oxygen gauge showed the oxygen canister was empty. Resident #6 awoke when asked how she was feeling. The resident responded, tired, and closed her eyes again. There were no staff in the immediate vicinity.During an observation and interview on 3/12/26 at 9:50 a.m., staff member L replaced resident #6's oxygen. She stated she was not sure if the resident was on scheduled or PRN oxygen, then checked the resident's oxygen order in the medical record. Staff member L read resident #6's oxygen order out loud and stated the order was confusing but thought she would set resident #6's oxygen administration to two liters of continuous oxygen. Staff member L stated it was difficult to determine what should be done for resident #6.A review of the facility's policy and procedure titled, Oxygen Administration, with an implementation date of 4/11/25, showed, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.1. Oxygen is administered under orders of a physician, except in the case of an emergency.4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to:a. The type of oxygen delivery system.b. When to administer, such as continuous or intermittent and/or when to discontinue.c. Equipment setting for the prescribed flow rates.d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered.e. Monitoring for complications associated with the use of oxygen.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff had the competencies and skills to provide care for 1 (#11) of 38 sampled residents. The deficient practice caused the resident concerns for safety and had potential to cause the resident infection, harm, pain and unmet care needs. Findings include:During an interview on 3/11/26 at 11:10 a.m., resident #11 stated staff had at times pulled on his nephrostomy tubes during care. Resident #11 stated that staff needed training on the care of nephrostomy tubes and that one of his nephrostomy tubes had been dislodged as a result.During an interview on 3/11/26 at 11:21 a.m., staff member J and staff member P stated they had not received training on the care of a resident with nephrostomy tubes. Staff member P stated they were shown how to empty urine and to notify the nurse if it wasn't draining.During an interview on 3/11/26 at 11:25 a.m., staff member Q stated she had not received training from the facility on how to care for a resident with a nephrostomy tube. Staff member Q provided nursing care and services. Staff member Q stated that she learned on the fly after resident #11 was admitted to the facility. Staff member Q stated that resident #11 taught her how to take care of his nephrostomy tubes and that staff member Q and resident #11 had done research on the internet so they could both learn more about his condition and normal nephrostomy tube function.During an interview on 3/11/26 at 12:10 p.m., staff member R stated she sometimes was assigned to resident #11. Staff member R stated the facility had not provided training on how to care for nephrostomy tubes. Staff member R stated resident #11 showed her how to take care of his nephrostomy tubes and that resident #11 was her first resident with nephrostomy tubes.During an interview on 3/11/26 at 12:30 p.m., staff member B stated she reviews admissions to identify care and training needs prior to a resident being admitted to the facility. Staff member B stated she approved new admissions clinically and was responsible for arranging training of the nursing staff to ensure they were able to provide safe care for the residents being admitted to the facility. Staff member B stated that resident #11 was an interfacility transfer, and staff member B did not identify the need to train facility staff on the care of nephrostomy tubes prior to resident #11 being admitted to the facility. Staff member B stated the facility should only accept residents that the facility can safely provide care for.A review of resident #11's progress note, created on 2/23/26 at 4:46 p.m., showed: Secure Message:[DATE] . [Saturday]. The tube is out 5 inches from the stitches; no urine output. resident stated tube was pulled out by a CNA on Wed or Thur. and stopped draining urine today. [sic]A review of resident #11's progress note, created on 3/11/26 at 3:29 p.m., showed: NHA spoke with resident on the incident with CNA where his nephrostomy tube had come out.Stated he asked the CNA to help pull his shirt down and in the process, the tube had come out. [sic]

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to have an updated written agreement with a hospice, which was signed by an authorized representative of both the hospice and the facility, before hospice care was furnished at the facility to ensure coordination and communication of care was provided as ordered for 2 (#s 29 and 65) of 3 residents sampled for hospice services. This deficient practice increased the risk to any resident receiving hospice services. Findings include:Review of the facility's hospice agreements provided during the Entrance Conference, showed an agreement signed and dated on 6/24/00, for Coordination of Services Agreement Between [NF7] and [NF8]. (Neither company exists any longer).During an interview on 3/11/26 at 8:15 a.m., staff member A stated the hospice agreement provided was representative of the agreement the facility had between NF6 Hospice and the facility. Staff member A stated they currently did not have an updated hospice agreement. Staff member A stated it was the expectation for the facility to have an updated and current hospice agreement with all hospice agencies providing services at the facility.During an interview on 3/11/26 at 3:30 p.m., staff member N stated she had spoken with staff member A, who confirmed the facility currently did not have an updated hospice agreement with NF6 Hospice, other than the one which was provided at the entrance conference. Review of resident #29's EHR, showed the resident was receiving hospice services provided by NF6, with a start of care date of 12/17/25, and a benefit period from 12/17/25 to 3/16/26.Review of resident #65's EHR, showed the resident was receiving hospice services provided by NF6 Hospice, with a start of care date of 1/7/26.A review of the facility's policy and procedure titled, Coordination of Hospice Services, with an implementation date of 4/11/25, showed, 1. The facility maintains written agreements with hospice providers that specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care.