STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275035	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Missoula Health & Rehabilitation Center	3018 Rattlesnake Dr Missoula, MT 59802

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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 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, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen by ensuring staff with facial hair wore beard coverings while working in the kitchen. The deficient practice had the potential to affect all residents who received food prepared in the facility's kitchen by increasing the risk of hair contamination in the food. Findings include:During an observation on 3/23/26 at 1:56 p.m., staff member L was observed with facial hair and was not wearing a beard cover while working in the kitchen.During an interview and observation on 3/25/26 at 11:51 a.m., staff member M was observed working in the kitchen with facial hair and was not wearing a beard cover. Staff member M stated he should have been wearing a beard covering because of his facial hair.During an interview on 3/25/26 at 11:53 a.m., staff member L stated staff with facial hair are required to wear beard coverings while working in the kitchen.Review of the facility's policy titled, Personal Hygiene Standards, updated June 2021, showed, .2. The following standards have been adopted by the FANS (Food and Nutrition Services) Departments:.k. For those employees with beards, beard guards are worn.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure temperatures were monitored daily by staff for a refrigerator that contained stored medications and vaccines. This failure placed residents who had or used refrigerated medications and vaccines at risk for experiencing adverse effects. Findings include: During an observation and interview on 3/26/26 at 8:51 a.m., staff member Q stated the two refrigerators in the provider office were used to store medications and supplements. Staff member Q stated the night shift nurse was supposed to check the refrigerator temperatures during their shift. Staff member Q stated he could see some temperatures were missing from the log sheets with daily temperature monitoring displayed on both refrigerators. The refrigerator had multiple types of medications and biologicals, including Tubersol (for tuberculin skin testing) boxes and influenza vaccine (FLUAD) boxes.Review of a facility document titled, Temperature Log for Refrigerator - Fahrenheit, dated 3/26, showed two pages of logs for temperatures for March 2026. One page showed temperatures for days 1-15, and the second page had temperatures for days 16-31. On the days of March 20 and 21 (2026), there were no staff initials, times, or temperatures noted on the log.Review of a facility policy titled, Storage of Medication, dated 1/25, showed: . Medications and biologicals are stored properly. to keep their integrity and to support safe, effective drug administration. 11. Medications requiring refrigeration or temperatures between . 36 F and . 46 F. are kept in a refrigerator with a thermometer to allow temperature monitoring. A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits. The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily. If no vaccines are stored in the refrigerator, document temperature checks at least once daily.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it had an effective process in place for the most current code status on POLST (Physician Orders for Life-Sustaining Treatment) forms and advance directives to be readily accessible in the electronic medical record, and available to staff, in the event of an emergency, for 2 (#s 30 and 31) of 22 sampled residents. Findings include:During an interview on [DATE] at 1:16 p.m., staff member R stated resident POLST forms and advance directives were kept at the nurses station in hard copy only. Staff member R stated the forms were not kept in the electronic medical record because of the need to have them available and to update for recent changes, in case of an emergent situation.During an observation and interview on [DATE] at 1:26 p.m., staff member S walked to the nurses station and requested to use the binder which held resident POLST forms and advance directives. Staff member S stated she did have to come up to the nurses station to check on resident code statuses. Staff member S looked for resident information in the binder and passed the binder back to the surveyor.During an interview on [DATE] at 8:14 a.m., staff member R stated POLST forms for residents were kept in a binder at the nurses station and not scanned into their medical record. Staff member R stated it had been like that since the facility went to electronic records from paper charts in 2012. Staff member R stated nurses have an SBAR (Situation, Background, Assessment, and Recommendation) form they can use for entering a resident's code status in the medical record. 1. Review of resident #30's POLST, dated [DATE], showed the form was completed by his medical power of attorney, with a selection of Do Not Attempt Resuscitation (DNR), no artificial nutrition by tube, and treatment options to include comfort measures only. Review of resident #30's care plan showed an admission date of [DATE], with a pertinent diagnosis of intractable epilepsy with status epilepticus, and did not include information regarding resident #30's code status or advance directives. Review of resident #30's medication and treatment administration record for [DATE] showed no listed physician's orders for code status. The section for Advance Directive showed, For Advance Directives and Code Status and/or POLST, see Disaster Recovery binder at nursing station. Review of resident #30's electronic medical record showed a document for a funeral trust was uploaded to the documents section under the category Advance Directives. The section displayed under the resident's name titled, Code Status: Advance Directives, showed: For Advance Directives and Code Status and/or POLST, see Disaster Recovery binder at nursing station.2. Review of resident #31's POLST, dated [DATE], showed the form was completed by his medical power of attorney, with a selection of No CPR, no artificial nutrition by tube, and medical interventions to include selective treatment, and showed, I want him to have oxygen always if needed! Review of resident #31's care plan showed an admission date of [DATE], with a pertinent diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and did not include information for resident #31's code status or advance directives. Review of resident #31's medication and treatment administration record for [DATE] showed no listed physician orders for code status. The section for Advance Directive showed, For Advance Directives and Code Status and/or POLST, see Disaster Recovery binder at nursing station. Review of resident #31's electronic medical record showed no advance directives or POLST forms were uploaded to the documents section under the category Advance Directives. The section displayed under the resident's name titled, Code Status: Advance Directives, showed: For Advance Directives and Code Status and/or POLST, see Disaster Recovery binder at nursing station. Review of a facility policy titled Advance Directives, revised [DATE], showed: . 2. During the admission process, the facility identifies if the resident has an advance directive or medical orders related to life sustaining treatment. If the resident does, a copy is requested and kept in the resident's medical chart, accessible to the physician and care staff. 10. The resident's comprehensive care plan is reviewed and updated (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	routinely in order to incorporate the resident's choices regarding these rights into treatment, care and services. Review of an online reference, located at https://boards.bsd.dli.mt.gov/medical-examiners/provider-orders-life-sustaining-treatment/faq and accessed on [DATE], showed: . The Provider Orders for Life-Sustaining Treatment (POLST) form represents a way of summarizing wishes of an individual regarding life-sustaining treatment. The form is intended for any individual with an advanced life-limiting illness. The form accomplishes two major purposes: it is portable from one care setting to another and it translates wishes of an individual into actual medical orders. The POLST form facilitates the process of translating end-of-life discussions with patients into actual treatment decisions, and provides security for the individual and physician that the expressed wishes will be carried out. There is no other form that streamlines the process in this way. If you have a signed POLST form, The Department of Public Health & Human Services and Board of Medical Examiners recommends you also have an advanced directive, though it is not required. You may obtain more information about advanced directives from your provider.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure the Brief Interview for Mental Status (BIMS) was completed correctly on the Minimum Data Set Assessment, and failed to conduct the required staff assessment for the resident's mental status when the resident was unable to participate in the Brief Interview for Mental Status (BIMS) for 1 (#7) of 22 sampled residents. The failure resulted in an inaccurate representation of the resident's cognitive status and placed the resident at risk for inappropriate care planning and interventions. Findings Include:During an interview on 3/25/26 at 2:07 p.m., staff member D stated resident #7 was Out of it, when he was admitted to the facility. Staff member D said that when she completed Section C, the Brief Interview for Mental Status (BIMS), resident #7 either didn't respond to the interview questions or the resident provided nonsensical responses during the entire interview. Staff member D stated that a staff assessment should have been completed due to resident #7's inability to meaningfully participate.Review of resident #7's admission Minimum Data Set, with an assessment reference date of 3/6/26, showed:Section B (Hearing, Speech, and Vision): resident #7 was coded as usually making himself understood and usually understood others.Section C (Cognitive Patterns): Brief Interview for Mental Status Score (C0500) coded as 00, a severe cognitive impairment. No staff assessment was completed.There was no documentation to support the Brief Interview for Mental Status interview that met criteria for a completed interview, nor was there evidence that the required staff assessment was initiated after an incomplete interview.Review of the CMS RAI Version 3.0 Manual, Section C (Cognitive Patterns) showed:A BIMS interview is considered complete only if the resident: Attempts and provides relevant responses to at least four items (C0200-C0400)The interview must be stopped if: Responses are nonsensical, irrelevant or no response was provided.If the interview is incomplete, staff must: Code 99 in C0500, Code 1 (Yes) in C0600 (Staff Assessment Required), and complete the Staff Assessment for Mental Status (C0700-C1000).The manual further clarified that nonsensical responses or lack of responses to four or more items constitute an incomplete interview, requiring a staff assessment.Resident #7 did not provide meaningful or relevant responses during the Brief Interview for Mental Status, as revealed in staff member D's interview on 3/25/26. The facility coded a completed score of 00 rather than 99 (unable to complete). The facility failed to trigger and complete the required staff assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure timely assessment, implementation of appropriate wound care orders, and coordinated follow-up after a skin concern was initially identified by the therapy department for 1 (#7) of 22 sampled residents. This failure resulted in delayed assessment and treatment of a developing pressure injury, placing the resident at risk for worsening skin breakdown and impaired healing. Findings include:During an observation on 3/23/26 at 2:48 p.m., resident #7 was observed in his room, seated in his wheelchair in a reclined position. During an observation on 3/24/26 at 4:44 p.m., resident #7 was observed in his room, asleep in his wheelchair in a reclined position. During an observation on 3/25/26 at 1:40 p.m., resident #7 was observed in the common area in his wheelchair in a reclined position. During an interview on 3/25/26 at 10:12 a.m., staff member B stated that when a skin concern was identified, the wound nurse is responsible for assessing and staging (determining severity) the wound, notifying the provider, and obtaining physician orders, which are then implemented on the medication and treatment administration record until the wound is resolved. Staff member B reported she was notified by the therapy department on 3/24/26 while resident #7 was assisted with toileting. Staff member B stated she did not approve of resident #7 being up in the chair for prolonged periods, noting, He's up almost all day in that chair, and stated the resident would benefit from being repositioned in bed to reduce pressure (on skin). She further stated the therapy department had been directing the resident's daily positioning and care. Staff member B said she was not aware of the skin concern before 3/24/26 and had not been informed of the initial identification on 3/19/26, after the skin concern was first identified. During an interview on 3/25/26 at 10:31 a.m., staff member K stated the skin concern for resident #7 was initially identified by the therapy department the previous week, at which time the area was described as dry and reddened. Staff member K further reported that by the day prior (3/24/26), the area had progressed to being open and peeling, revealing a decline in skin integrity. Staff member K said they have been trying to keep resident #7 up in his chair in the mornings and lay him down after lunch. This information demonstrates that the skin concern was identified days before the skin opened, yet a timely follow-up assessment and interventions were not implemented to prevent progression. During an interview on 3/25/26 at 10:43 a.m., staff member P said resident #7's daily routine was to be up in his chair for all meals and then lie down after meals, Because of his bottom. During an interview on 3/25/26 at 1:25 p.m., NF2 said she had mixed messages from staff related to the wound on resident #7's buttock. NF2 stated, Some people have said yes, something is going on, and some people say nothing is going on, related to resident #7's buttock wound. During an observation on 3/25/26 at 1:32 p.m., staff members F and G provided peri-care for resident #7. When resident #7's brief was removed, the resident had a large circular basketball-sized reddened area around his gluteal area with a circular imprinted dimpled area around the circumference of the reddened area. The reddened area was blanchable. Inside the reddened area was a large padded dressing covering the intergluteal cleft (the crack between the buttocks), the coccyx, and the gluteal (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	region. The dressing was dated 3/24/26. Staff member H entered the room to perform wound care for resident #7. When staff member H removed the dressing, there was an open area of skin, which was approximately one centimeter (the size of a pencil eraser) circular wound with partial thickness skin loss exposing the dermis. The open area appeared bright red and shallow, with no drainage. Staff member H cleansed the wound and reapplied a large white dressing to the area. There were no measurements obtained by staff member H during the observation. During an interview on 3/25/26 at 3:11 p.m., staff member H stated she was notified of resident #7's wound/skin area yesterday (3/24/26) during morning cares. She stated the area was opened yesterday, and she cleansed the site and applied a dressing. She stated she did not obtain any measurements or assessments of the area since she was not as familiar with the staging of pressure injuries. She stated she had notified staff member B since the wound care nurse was out on leave. She stated she would normally notify the wound care nurse and the provider of any new pressure areas noted on a resident. Staff member H stated she felt the open area on resident #7's buttocks would heal quickly with barrier cream. Review of resident #7's Physical Therapy Treatment Encounter Note, dated 3/19/26, showed, .It also became apparent that patient was beginning to demonstrate signs of breakdown. Nurse is notified and she is able to place both cream and protective barrier. Review of resident #7's electronic health record showed the following: - Daily Skilled Evaluation for Falls/Weakness note, dated 3/19/26, .Noted gluteal skin reddened, risk for breakdown. Cleansed, barrier cream and prophylactic dressing applied. Therapy x2 assisted with brief change. - Daily Skilled Evaluation for Falls/Weakness note, dated 3/24/26, .Left gluteal wound cleansed and dressing applied. Barier cream applied on peri-area. [sic] - Daily Skilled Evaluation for Falls/Weakness note, dated 3/25/26, .Left gluteal shear wound care done, note no drainage, or signs of infection, no pain. - Weekly Skin Evaluation, dated 3/25/26, .Wound site: Buttock Right, Wound is described as shearing of skin dry flake, Length in centimeters: 5, Width in centimeters: 5, Depth in centimeters: 0, Shape of wound: oval .This is the first observation of this wound. The weekly skin evaluation dated 3/25/26 inconsistently identified the wound as the first observation and located it on the right buttock, reflecting discrepancies in the documentation and delayed recognition of the wound's progression. Review of resident #7's medication and treatment administration record for March 2026 showed the following orders: -Weekly Skin Audit every day shift every Mon Nurse Initials - Head to Toe Skin Evaluation completed. If new skin impairment is found, document in Progress Notes, notify Medical Provider, and initiate Weekly Skin Evaluation. Start Date- 03/09/2026 6:00 a.m. - Left gluteal wound - cleanse with wound wash, pat dry and cover with dry dressing once daily and PRN one time a day for wound care -Start Date- 03/24/2026 10:00 a.m. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medication and treatment administration record showed wound care orders were not initiated until 3/24/26, despite identification of skin breakdown on 3/19/26. This demonstrates a failure to ensure timely follow-up, accurate assessment, and consistent documentation after initial identification of skin breakdown, resulting in progression of the wound. Review of the facility's policy titled, Skin Integrity, updated January 2026, showed, Policy Statement: It is the policy of this center that a resident who enters the center without pressure ulcer/injury does not develop pressure ulcer/injury unless the individual's clinical condition demonstrates that they were unavoidable and a resident having pressure ulcer/injury receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 4. For new skin impairment identified, the LN completes the following: a. Documents the skin impairment that includes measurements of location, size, color, presence of odor, exudate, and presence of pain associated with the skin impairment. [sic]

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to follow professional standards and practices to ensure a resident's electronic medical record contained accurate information for the administration of a medication for 1 (#44) of 22 sampled residents. Findings include:Review of resident #44's list of physician orders showed: .Order: busPIRone HCl Oral Tablet 15 MG (Buspirone HCl), Directions: Give 1.5 tablet by mouth two times a day, Category: Pharmacy, Status: Active, Start Date: 3/18/26, Revision date: 3/23/26.Supply Date Dispensed: 3/18/26, Date Received: 3/18/26, Status: on hand, Medication: busPIRone HCl 15 MG Tablet, Directions: Take 1 & 1/2 tablet (22.5 MG) by mouth twice daily for hypertension.During an interview on 3/25/26 at 7:56 a.m., resident #44 stated her medications were previously messed up, but the staff had straightened them out. Resident #44 stated that Buspirone is for her anxiety. During an interview on 3/25/26 at 7:59 a.m., staff member B stated that when a resident arrives at the facility, the ADON enters the medication orders, and the DON double-checks them. Staff member B stated she did not know why the order showed hypertension and did not know how it was entered that way. Staff member B stated she had done an audit and noticed it had the wrong diagnosis and changed it immediately. During an observation and interview on 3/25/26 at 10:10 a.m., staff member N stated the rationale for resident #44's buspirone was hypertension, according to the label on the medication card. Staff member N pulled out the medication card and showed this surveyor. The medication card for resident #44's buspirone showed .for hypertension. Staff member N stated the medication administration record is the same as the medication card from the pharmacy.During an interview on 3/25/26 at 4:16 p.m., staff member O stated buspirone does not have any hypertensive agents but could be used to reduce anxiety and, as a result, reduce hypertension.During an interview on 3/26/26 at 8:49 a.m., NF3 stated she was not sure how hypertension got attached to resident #44's buspirone order. NF3 stated, She (resident #44) has a history of depression and anxiety, but the medication is definitely not for hypertension. NF3 stated she (resident #44) does see psych services, and she came to the facility on that medication. Review of a facility document titled Medication Administration General Guidelines dated 1/25, showed: Policy: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices.3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a direction change sticker to label if directions have changed from the current label.