STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275043	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health & Rehabilitation	2651 South Ave W Missoula, MT 59804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions, staff failed to wear hair restraints in the kitchen area, and the facility failed to provide food at a safe and appetizing temperature for 4 (#s 6, 14,72, and 154) of 34 sampled residents. These deficient practices placed all residents who consumed meals prepared by the facility at risk of exposure to food-borne pathogens and or illness. Findings include:During an observation of the kitchen on 8/25/25 at 3:12 p.m., the following concerns were identified: - The juice dispenser had a sticky liquid on the dispenser nozzles, the front panel of the dispenser, and the backsplash.- The coffee dispenser had dried coffee on the front tray and on the dispenser nozzles.- A light brown liquid was spilled on the counter by the coffee dispenser. A drawer containing utensils was open under the spill, and the brown liquid had spilled into the utensil drawer.- There was ice buildup in the freezer, and there was ice on the floor of the freezer, which made the floor slick and hazardous. The ice buildup extended on the outside of the freezer due to the worn door seal. - An open package of unlabeled meat, not dated, was observed in the walk-in cooler. The package was mixed in with other types of meat, including pork and pastrami products.- Ham was observed in a pan, covered with cellophane, which was labeled but undated.- Food particles, grease, dust, grime, and an unknown light brown sticky substance were observed in the corner to the right of the freezer door. Above this, on the outer surface of the walk-in freezer, was a black substance.- Particles of food, grease, dust, and grime were noted on the ledge of the whiteboard to the right of the freezer.- An open bin containing whole onions was stored under a food preparation sink.- Pieces of food were noted on the counter around and under the food mixer.- A cabinet to the right of the food mixer had dried splatter on it.- Particles of food, grease, dust, and grime were noted on the windowsill above the food preparation sinks.- There was hard water buildup observed on the outside of the ice machine, on top of the machine, and down the front of the lid.- A cooler in the dry storage area contained a pitcher of thick red liquid labeled tomato and the pitcher was not dated.During an interview on 8/25/25 at 3:36 p.m., staff member P, when discussing the individual condiment packages (which were not dated) stored on a shelf outside of the dietary manager's office, stated, . if they aren't marked (dated), we don't know when to get rid of them.During an observation on 8/25/25 at 3:38 p.m., staff member D entered the dietary area and walked through the kitchen without a hair cover or net. Staff member D stated she was off the clock and just gathering some personal items. She stated she would assist in the kitchen at times, and she was a certified nursing assistant. During an observation on 8/26/25 at 7:57 a.m., staff member D was observed talking to an unknown kitchen staff member in front of the walk-in cooler in the dietary department, and staff member D did not have a hair covering on at the time.During an interview on 8/26/2025 at 8:19 a.m., staff member K stated CNAs will deliver the meal trays to the resident rooms when a resident chooses not to go to the dining room for the meal. Staff member K stated the food is brought to the hall in the food carts by dietary staff, and the food stays in the cart until it is delivered to the resident. He stated that meals are delivered warm when placed in the cart, and at times, the food has to be heated before serving. He stated the CNAs heat the food, when needed, to 165 degrees Fahrenheit. During an observation and interview on 8/26/25 at 8:33 (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a.m., resident #6 was in bed with her meal tray on her overbed table. She was stirring food in a bowl that she reported to be oatmeal. The oatmeal was thick with large clumps and did not easily mix when she stirred it. She reported the oatmeal was not warm.During an interview on 8/26/25 at 8:51 a.m., resident #154 stated, Food is a big concern. Half the time it comes in cold. I have gotten sick off the food a couple times. I don't think they temp the food. During an observation on 8/27/25 at 8:37 a.m., food trays were stored in a cart on the 300 hall and were being delivered to the residents by staff. A tray still in the cart, labeled for resident #72, was checked for the temperature of the food by staff member M, who was using a facility thermometer. The temperature showed the temperature of the sausage on the tray was 110.9 degrees Fahrenheit.During an observation on 08/27/25 at 8:40 a.m., food trays were stored in a cart on the 300 hall and were being delivered to the residents by staff. A tray in the cart, labeled for resident #14, was checked for the temperature of the food by staff member M, who was using a facility thermometer. The temperature of the cooked eggs on the tray was 116.2 degrees Fahrenheit.During an observation on 08/27/25 at 8:46 a.m., food trays were stored in a cart on the 200 hall and were being delivered to the residents by staff. A tray in the cart, labeled for resident #154, was checked for the temperature by staff member M, who was using a facility thermometer. The temperature of the cooked sausage on the tray was 114.3 degrees Fahrenheit.During an observation and interview on 08/27/25 at 8:49 a.m., resident #6 was in bed and had just begun eating. Her tray was on the overbed table with the lid still on her plate. The temperature of the eggs on resident #6's plate was checked by staff member M using a facility thermometer. The temperature of the eggs was 110.8 degrees Fahrenheit. Resident #6 stated the food was not as warm as she would like it to be.During an observation on 8/27/25 at 8:57 a.m., it was observed that the ice bin lid was left open. There were no staff in the area at the time. There was also a Ziplock bag containing individual, single-serve creamer packets, on the floor in the dry storage area. During an interview on 8/27/25 at 9:00 a.m., staff member N stated a hair net or hat is required to be worn at all times when in the kitchen. He stated that food in the cooler should be dated so staff knew when to get rid of it. When asked about cleaning schedules in the kitchen he stated everything in the kitchen was cleaned daily and equipment was cleaned after each use. During an interview on 8/27/25 at 9:22 a.m., staff member D stated hair and beard coverings are required when in the kitchen, and staff should absolutely not be in the kitchen without them at any time.During an interview on 8/27/25 at 9:26 a.m., staff member E stated he met with the staff in the kitchen every Monday and Friday, and he reminded them that hair coverings were always required in the kitchen, but staff member E was not aware of any staff member entering the kitchen without a hair covering. When interviewed about the kitchen concerns, staff member E stated the nozzles on the coffee dispenser were cleaned two weeks ago by the distributor, but he knew it should be done more often. He stated the juice machine nozzles were cleaned once a week, and he expected staff to close the ice machine lid and never leave it open. Staff member E stated that all meat needed to be dated once the meat is thawed. Meat is thawed either in the walk-in cooler or in the sink under cool running water. Staff member E stated that different meats should be stored separately to prevent cross contamination and that meats were dated to ensure they were not used when no longer safe for consumption. When asked about the seal on the freezer door, staff member E stated it had not been sealing properly for a long time but that the facility had ordered a replacement door. He stated that he believed it took a while as it had to be special ordered. Staff member E stated the temperature of the food being held in the carts had been an ongoing problem, and the facility was trying to fix the problem. He stated the food temperature concerns were addressed last year, and they switched from the old metal lids for the plates to the current plastic insulated ones. Staff member E stated the new lids maintain the food temperatures within an acceptable range for about 30 minutes, but if it goes longer, the food cools down.During an interview on 8/27/25 at 11:53 a.m., staff member L stated food trays must frequently be reheated due to some foods not being warm enough when the trays are taken from the meal carts and then delivered to the residents in their rooms.Review of a facility (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	provided document titled, Hair and [NAME] Restraint Policy, last reviewed 8/26/2025 showed: Policy: All employees involved in the production of food in the kitchen must have hair and facial hair covering without exception.A review of a facility provided document titled Food Safety Requirements, last reviewed 8/26/2025, showed: Policy Explanation and Compliance Guidelines:. 3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage .b. Dry food storage-keep foods/beverages in a clean, dry area off the floor .c. Refrigerated storage.iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date.Review of a facility provided document titled Food Temperatures, last reviewed 8/26/25 showed: Policy: The temperatures of all food items will be taken and properly recorded prior to service of each meal.Procedure:1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F b. Hot food items may not fall below 135 degrees F after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees F and reheated to at least 165 degrees F prior to serving. 5. Food preparation and service areas will avoid the following methods:a. Holding foods in the temperature danger zone (41 degrees to 135 degrees F). [sic]

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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. Based on interview and record review, the facility failed to ensure licensed nursing staff had the necessary knowledge and skillset on the facility's post-fall protocol and physician notification, and a resident had a fall, with an injury and pain, and the proper notifications were not all made, for 1 (#85) of 34 sampled residents, and this resulted in a delay in care. Findings include:During an interview on 8/26/25 at 9:36 a.m., resident #85 explained she had a fall when her leg got caught during a transfer, and she fell because the nurse went to get help and left her standing at the edge of the bed with nothing to hold on to. During an interview on 8/27/25 at 9:48 a.m., staff member O stated resident #85 transferred with a walker and a one-person assist and was 50% weight bearing on her right leg. Staff member O stated the resident fell when moving from the bed to the recliner. Staff member O stated resident #85 was reporting pain in her right knee at the time of the fall. Staff member O stated the fall protocol was to notify the family, the physician, and write up a fall report. Staff member O stated he didn't realize there were other required reports to complete at the time of the fall, such as the incident and risk management charting. Staff member O stated he did not notify the physician on call after the resident fell. Staff member O stated he felt like he did not know how to do a lot of things at the facility and said, I had to fight tooth and nail to get any orientation here. I still don't feel fully enabled on how to do my job.During an interview on 8/27/25 at 10:30 a.m., NF5 stated she was the nurse attending to resident #85 upon admission to the emergency room, on the day after resident #85's fall. NF5 stated she had concerns because the EMT who gave her a summary stated there was a different story from what the resident reported and what the facility staff reported. NF5 stated resident #85 had fallen earlier in the day and presented with her right leg internally rotated and significantly shorter than the left leg, which were indications of a broken extremity. NF5 asked resident #85 why her care was delayed and asked the resident if her leg always looked like this. NF5 stated the resident reported the nurse at the facility had advised the resident to wait to see if it was worse in the morning before transferring to the emergency department.During an interview on 8/27/25 at 3:46 p.m., staff member O was shown a facility document titled, [Corporation name] SNF Nurse Skill Competency Checklist, undated, which showed he had met the criteria for incident charting and fall safety. Staff member O stated staff member B simply asked him if he was competent or not and checked the boxes as met. Staff member O recalled he asked to read the competency checklist before he could answer if he was competent or not. Staff member O stated he was told to sink or swim (referring to staff member O's performance). Review of resident #85's medication administration record, dated August 2025, showed, Warfarin Sodium Oral Tablet 3 MG (Warfarin Sodium) Give 0.5 tablet by mouth one time a day every Mon, Wed, Thu, Fri, Sun for treating/preventing blood clots.start date 8/8/25 0700 (7:00 a.m.). [sic]Review of resident #85's EHR, showed a documentation note, dated 8/9/25 at 3:07 p.m., which showed details of the resident's fall. The note failed to show the physician was notified or that the resident's Warfarin and risk of bleeding was considered as a concern after the fall. Review of the facility's document titled, Notification of Changes, last review on 10/14/24, showed, Policy: The facility will inform the resident; consults with the resident's physician; and if known, notify the resident's legal representative or appropriate family members(s) of the following:1. An accident resulting in injury to the resident that potentially requires physician intervention.2. A significant change in the physical, mental or psychosocial status of the resident. Policy Explanation and Compliance Guidelines:1. In the case of a competent resident, the facility will contact the resident's physician and appropriate family member(s) .5. Document in the resident's clinical record the date and time of the notification. Review of the facility's document titled, Fall Prevention Program, last review date 1/23/25, showed: . 5. When a resident experiences a fall, the facility will:.d. Notify physician and family.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to provide a thickened therapeutic diet as ordered for 1 (#91) of 34 sampled residents. The failure increased the risk of aspiration for the resident. Findings include:Review of resident #91's care plan, dated 8/12/25, showed resident #91 was to be provided nectar-thick fluids, as prescribed by the Speech Language Pathologist on 8/16/24.Review of resident #91's medication administration record for August 2025 showed the resident was to have Boost Breeze, which was to be thickened to a nectar-thick consistency, or the Boost may be replaced with a thickened preferred supplement.During an observation and interview on 8/27/25 at 8:05 a.m., resident #91 was sitting at the breakfast table. Staff member D was observed putting three pumps of gel thickener into a glass of cranberry juice. The thickener was observed in the bottom of the glass. The juice was floating on top of the thickener. Staff member D did not stir the thickener into the juice to mix it to a nectar-thick consistency. Resident #91 had a thin consistency liquid protein supplement and thin consistency tomato juice, also served with the meal. While staff member D was assisting resident #91 with his breakfast, staff member D gave resident #91 a drink of cranberry juice. Resident #91 immediately coughed after drinking the thin consistency juice. Resident #91 continued to cough throughout his meal. During this observation, the dietary meal ticket was observed, and it showed the fluids should be a mild to nectar-thick consistency. Staff member D spooned some juice, and the juice was a thin consistency. Staff member D stated, I put three pumps (of thickener) in the glass. It is not thick at all - I stirred it, but it floated back to the bottom. It was observed the staff did assist the resident and he had ceased coughing before the end of the meal. During an interview on 8/27/25 at 8:05 a.m., staff member E said resident #91 should have mild nectar-thick fluids, but the cranberry juice, the tomato juice, and the Ensure resident #91 had at the table weren't thickened at all. Staff member E said nursing could answer questions about education for thickening fluids because the nurses thickened the fluids. Staff member E said the kitchen would thicken fluids for the residents who received room trays.During an observation and interview on 8/27/25 at 8:33 a.m., the surveyor showed staff member F resident #91's water pitcher. Staff member F said the water consistency in the pitcher was not right at all because resident #91's care plan was for thickened fluids. Staff member F said resident #91 should have had thickened water provided in his bedside pitcher, not the regular water contained in the pitcher.On 8/27/25 at 3:35 p.m., the education on thickening fluids for the residents, provided to nursing and dietary staff, was requested. The facility provided staff member D's certified nurse assistant checklist. No other education was received by the end of the survey.