

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024
NAME OF PROVIDER OR SUPPLIER Mount Ascension Transitional Care of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 2475 Winne Ave Helena, MT 59601	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>50245</p> <p>Based on observation, interview and record review, the facility failed to ensure physician orders were present in the EHR for 2 (#s 2 and 5) residents; and failed to ensure oxygen supplies/equipment were labeled consistently to show the date the supplies were cleaned or changed, for 5 (#s 1, 4, 5, 6, and 7) sampled residents. Findings include:</p> <p>During an observation and interview on 12/16/24 at 12:15 p.m., resident #4 stated his oxygen tubing was not labeled until this morning. The tubing had a date of 12/16. Resident #4 stated he never saw the tubing labeled before this date. Resident #4's oxygen humidifier was not dated.</p> <p>During an interview on 12/16/24 at 2:30 p.m., resident #1 stated she did not see her oxygen tubing labeled prior to that day.</p> <p>During an observation and interview on 12/16/24 at 2:37 p.m., resident #7 stated her oxygen tubing and nebulizer were placed in a plastic bag and labeled, this morning, but prior to day, the respiratory supplies were not labeled with a date.</p> <p>During an interview with resident #6 and NF1, on 12/16/24 at 2:48 p.m., NF1 stated, That's brand new, when referencing resident #6's oxygen tubing and the date documented on the tubing. NF1 stated the oxygen tubing was not usually labeled.</p> <p>Review of resident #5's physician orders, showed no oxygen order documented or in place for the resident.</p> <p>During an interview and observation, on 12/16/24 at 3:11 p.m., resident #5 was receiving 3 liters of oxygen through a nasal cannula. Resident #5 stated her nebulizer, CPAP, and oxygen tubing, had never been labeled with a date or placed in a bag (by staff members) like it was during the observation made that day. Resident #5 stated she did not ever see any staff member clean her nebulizer or CPAP.</p> <p>Review of a facility document, titled Legionella Water Management Plan, not dated, showed, . CPAP, Bipap and Nebulizers are cleaned weekly per policy (Hot soapy water) .</p> <p>During an interview on 12/16/24 at 4:54 p.m., staff member C stated an oxygen order was absolutely necessary as the oxygen was considered to be a medication.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/16/24 at 5:05 p.m., staff member D was unsure if an oxygen order was needed for a resident requiring oxygen. Staff member D stated the facility did not have standing orders for oxygen.</p> <p>During an interview on 12/17/24 at 12:25 p.m., staff member F was unsure how frequently oxygen tubing needed to be changed, but stated a physician's order should be present in the resident's record, which would specify the frequency (use of oxygen).</p> <p>Review of resident #2's physician orders showed there was no oxygen order documented or in place in the resident's medical record.</p> <p>During an observation on 12/17/24 at 12:52 p.m., resident #2 had an oxygen concentrator in her room.</p> <p>Review of the facility policy, titled Oxygen Therapy, with a revision date of 8/4/24, showed: .1. Verify physician order prior to initiating oxygen therapy .</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>50245</p> <p>Based on observation, interview, and record review, the facility failed to encourage and properly implement resident dietary preferences for 1 (#10); and failed to have a consistent process in place to address therapeutic diets over the weekend, when a new diet was ordered/modified, to ensure the change was addressed timely for safety, for 1 (#10) of 10 sampled residents. Findings include:</p> <p>During an interview on 12/16/24 at 3:57 p.m., resident #10 stated she only had problems swallowing food when it was a dry or tough meat like chicken or pork. Resident #10 stated she had no problems swallowing any other foods. Resident #10 stated dry meats were easier to swallow if they had a sauce or gravy added to it. She stated she had expressed her concerns with eating the dry meat during a care conference earlier in the month. Resident #10 stated, just this morning (12/16/24), her diet order had been changed, and there was no assessment for her swallowing ability completed by a staff member or the physician. Resident #10 stated she was able to cut up her food herself, if needed, and stated she did not understand why a minced pancake was appropriate for her. Resident #10 stated her food usually did not have any gravy because staff member H stated she had gained too much weight while at the facility. Resident #10 stated, I know it's been difficult for [staff member H] to work around my things (food preferences).</p> <p>Review of resident #10's EHR showed a physician's diet order, with a start date of 12/13/24 at 10:38 a.m., which was, Regular diet, L5: Minced/Moist, Mix Consistency texture, L0: Thin Liquid consistency.</p> <p>During an interview on 12/16/24 at 5:05 p.m., staff member D stated resident #10's diet order just changed today which was not consistent with the physician order dated 12/12/24. Staff member D stated there was not a swallowing evaluation completed, that D was aware of, but the facility had talked about doing a trial of a minced and moist diet with the resident.</p> <p>During an observation on 12/17/24 at 8:22 a.m., resident #10's plate had cubed pieces of ham, and a bowl of pureed orange liquid. The diet order read: orange juice; canned fruit, drained minced and moist; cream of wheat; scrambled egg with cheese. Resident #10's scrambled eggs did not have cheese.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview with resident #10 and staff member E, on 12/17/24 at 8:23 a.m., staff member E stated resident #10's physician's therapeutic diet order was not being followed for a minced and moist diet, and stated, That's too big of pieces for the ham. Staff member E stated the ham needed to be chopped up much finer to be considered acceptable. Staff member E stated the orange liquid substance in the bowl looked like thickened orange juice. Staff member E stated the orange liquid substance in the cup looked like un-thickened orange juice. Staff member E was unsure why the facility would give resident #10 a thickened and regular orange juice in different containers. Resident #10 stated she asked multiple times to not receive milk, due to a fear of a potential allergy, and then the resident pointed to the milk on her tray. Staff member E stated, I think if she doesn't want milk then she shouldn't have milk. Staff member E stated resident #10 had a preference, and that was okay for her to have. Staff member E stated, I don't know how they (facility) came up with that (the diet order for resident #10). Staff member E stated a diet order was typically changed when a resident had a previous diagnosis of a stroke or trouble swallowing. Staff member E voiced not seeing resident #10 choke while eating, or having any other problems, with swallowing.</p> <p>During an interview on 12/17/24 at 11:03 a.m., staff member H stated a minced and moist diet should allow a fork to go through the food, and the food should be moistened either with gravy, butter or ketchup. Staff member H looked at a photo of resident #10's breakfast (from 12/17/24), and stated the eggs might not have been prepared not following the minced and moist diet, due to the food not being minced. Staff member H stated resident #10 had received cubed ham instead of minced ham, because resident #10 did not like minced ham. Staff member H stated this did not follow her current diet, and stated, Her (#10) ham should have been minced. Staff member H stated the staff printed meal tickets for the weekend each Friday at 2:00 p.m. Staff H stated if an order came in after that point, it would have the potential to be missed until Monday, which was when staff member H returned to work. Staff member H stated, There's not usually any new diet orders or changes on Saturday(s) or Sunday(s). Staff member H stated resident #10 had gained ten pounds since being there, and had a concern regarding the resident's weight gain.</p> <p>Review of resident #10's EHR showed an admission weight on 10/31/24 of 241.2 pounds, and a current weight, which was dated 12/11/24, of 243.2 pounds.</p> <p>During an interview on 12/17/24 at 12:25 p.m., staff member F stated physicians were contacted by phone, and then staff member F would document in the EHR on the communication held with the physician.</p> <p>Review of resident #10's EHR showed no other nursing or physician notes regarding resident #10's swallowing abilities, except for a nursing note, dated 12/13/24. This was a late entry and documented on 12/16/24, and showed, MD assessed resident and gave orders to change diet to minced and moist d/t difficulty swallowing. ST to evaluate and treat.</p> <p>During an interview on 12/17/24 at 12:55 p.m., resident #10 stated her lunch did not have any gravy to moisten the meatloaf.</p> <p>On 12/17/24, a request was made for, Physician communication diet order change: [resident #10]. No communications were provided for the request prior to the end of survey.</p> <p>Review of a facility policy titled, Diet Orders & Nutrition Prescriptions, with a revision date of 8/1/23, showed:</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.Change of Diet Order: 1. Changes in diet orders are communicated to the Culinary Services department electronically or in writing within two hours of the order .</p> <p>Review of a facility policy titled, Therapeutic Diets and Meal Plans, with a revision date of 8/9/23, showed: .d. Food and drink that accommodates resident allergies, intolerances, and preferences .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50245</p> <p>Based on observation, interview, and record review, the facility failed to obtain water temperatures that were within the CDC's recommended temperatures to prevent the growth of legionella; and obtain water temperatures in resident areas for 4 (#s 1, 4, 5, and 8) of 10 sampled residents; failed to ensure temperatures were completed frequently enough to follow the facility policy; failed to provide staff with adequate Legionella education; and failed to properly clean areas where legionella could be found (such as the eyewash stations, an ice machine, and sinks/toilets specifically, for 1 (#9) of 10 sampled residents; and failed to ensure oversight or intervention was completed from the infection preventionist when a resident was recently diagnosed with legionella. Findings include:</p> <p>1. Review of a facility document, titled Risk Management Plan for Water Borne Illnesses, no date, showed, Table 6: Hot Water to Resident Areas: Testing of water temps: frequency: Weekly .</p> <p>Review of a facility document, titled Legionella Water Management Plan, not dated, showed:</p> <ul style="list-style-type: none"> - . Water is monitored and temp'd weekly . - Water is temp'd weekly to verify that it is between 100 and 120 degrees . <p>Review of a facility document, titled Tels, dated 10/21/24, showed the following temperatures were recorded for resident areas: 100, 99, 100, 100, 99, .</p> <p>Review of a facility document, titled Tels, dated 10/7/24, showed the following temperatures were recorded for resident areas: 98, 100, 101, 99, 100, .</p> <p>The facility Tels were completed every other week (9/10/24, 9/23/24, 10/7/24, 10/21/24) for obtaining water temperatures of the resident areas, although the policy was weekly temperatures to be obtained. According to the CDC, legionella's favorable range for bacterial growth is 77-113 degrees Fahrenheit (Centers of Disease Control and Prevention (CDC), 2024), and all the temperatures taken during the dates shown above were within that range.</p> <p>During an observation and interview on 12/16/24 at 12:15 p.m., resident #4 stated he had never seen staff member K enter his room to check water temperatures in the shared bathroom or the sink in his room.</p> <p>During an interview on 12/16/24 at 2:30 p.m., resident #1 stated she had never observed staff member K check water temperatures in her bathroom or sink(s).</p> <p>During an interview on 12/26/24 at 11:32 a.m., resident #8 stated she had never seen staff member K check anything in her bathroom in her time being at the facility.</p> <p>During an observation on 12/26/24 at 11:44 a.m., room [ROOM NUMBER] was empty, and the toilet was dirty, with light beige streaks in the toilet. In the sink, there was a greenish/brownish residue around the sink drain that could be scraped off.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/16/24 at 12:09 p.m., room [ROOM NUMBER] was also empty and had a greenish/brownish residue around the sink drain that could be scraped off.</p> <p>During an interview on 12/16/24 at 3:11 p.m., resident #5 stated she never seen staff member K checking water temperatures in her sink or in her bathroom.</p> <p>During an interview on 12/17/24 at 8:23 a.m., staff member E stated the eyewash station was nasty, and the sink that was located in a room near nurse's station had a residue around the sink drain, and near the faucet, that could be scraped off.</p> <p>During an interview and observation on 12/17/24 at 12:25 p.m., staff member F stated they had never specifically looked, but never noticed staff member K checking the temperature of the water at the eyewash station. Staff member F stated the eyewash station was disgusting, and would not want to use that if needed in an emergency. The eyewash station had the caps off and lying to the side. Inside both of the caps there was a light brown substance.</p> <p>During an interview on 12/17/24 at 2:00 p.m., staff member K stated to prevent Legionella, the toilets would need flushed, and then measuring water temperatures, and taking boiler temperatures. Staff member K stated he was not keeping a boiler temperature log because he could easily go look at it (to find the temperature). Staff member K was a bit unsure when answering questions regarding the frequency of how often to flush toilets to prevent Legionella bacteria growth. Staff member K stated, It just comes up on my stuff (on the Tels program which had reminders to complete a task). Staff member K stated he flushed the toilets every other week-ish. Staff member K stated, Every single toilet is being used, and all of the rooms were currently full.</p> <p>2. During three interviews, with staff members G (interview on 12/17/24 at 11:38 a.m.), staff member K (interview on 12/17/24 at 2:00 p.m.), and staff member F (interview on 12/17/24 at 12:25 p.m.) staff stated they did not receive any specific information regarding Legionella, especially information that would be pertinent for their respective job duties. Staff member F stated they were told to look for cough or pneumonia symptoms (in residents) but that was all that they knew. The staff stated they were unaware of the following symptoms for Legionella: muscle aches, head ache, chest pain, nausea, vomiting, and confusion. Staff member G stated being told to clean high touch areas, but not told anything specific regarding water, toilets, or sinks.</p> <p>During an interview on 12/17/24 at 1:09 p.m., staff member J stated they educated all staff as they were able to catch them on Legionella.</p> <p>A request was made on 12/17/24 at 4:29 p.m., for all of the staff education for the prevention of Legionella. No documentation was provided by the end of survey.</p> <p>3. During an interview on 12/16/24 at 12:15 p.m., resident #4 stated, They need to clean a little better, when he was referring to the bathrooms and sink in his room.</p> <p>During an interview on 12/17/24 at 10:28 a.m., staff member I opened the facility's ice machine and stated the light brown film inside looked gross. In this same area, there was a small dot about a few millimeters in circumference that was black and fuzzy. Staff member I stated staff member K or housekeeping was responsible for cleaning this.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/17/24 at 10:34 a.m., resident #9's sink had a greenish/brownish residue around the drain of her sink that could be scraped off.</p> <p>During an interview on 12/17/24 at 11:07 a.m., staff member H stated they were responsible for cleaning the ice machine and had done it last month. Staff member H did have a log, but stated they missed the back part.</p> <p>During an interview on 12/17/24 at 11:38 a.m., staff member G stated they were told to deep clean all the rooms about a month ago. Staff member G stated they had heard from a family member that the facility might have had legionella, but staff member G stated they did not remember the facility telling them any specific information regarding legionella or how to prevent the water borne illness from affecting residents and employees. Staff member G stated there was a residue on the bathroom sink in resident #9's room. Staff member G stated it could be a calcium buildup but stated that bacteria could easily harbor in this area. Staff member G stated they would easily be able to clean this with a toothbrush.</p> <p>4. During an interview on 12/17/24 at 1:09 p.m., staff member J stated the facility was tracking anything infection related. Staff member J stated, Our infections go through our doctors so they would tell us (if the infection needed to be reported) when referring to reportable diseases. Staff member J stated, (That's a) pretty broad question there, when answering how long it took for symptoms to show for legionella. Staff member J stated the whole building was not tested , but it was just based off of symptoms and nearby rooms of a resident that had gotten diagnosed with legionella. Staff member J stated, No, everything went through [physician name], when referring to if they had worked with [an entity] regarding the resident who was diagnosed with legionella. When asked why staff member J was not more involved in the infection control of the resident diagnosed with legionella, staff member J stated, Okay.</p> <p>During an interview on 12/17/24 at 2:00 p.m., staff member K stated legionella prevention was equally staff member J's responsibility. Staff member K stated, It's kinda [staff member J's] thing. Infection control should be in this meeting with me (now). Staff member K also explained they had a meeting with [an entity] and expressed that staff member J should have been present during that meeting as well. Staff member K stated the facility had not increased any preventative measures since a recent resident had gotten diagnosed with legionella. Staff member K stated prior to the incident, they had not been involved in the Legionella Water Management Plan.</p> <p>Review of a facility policy, titled Legionnaire Disease Outbreak Protocol, dated 1/1/2018, showed:</p> <ul style="list-style-type: none"> - .11. Provide staff education as necessary on Legionnaire's Disease . - 3. Document staff education in the employee's education file . <p>References:</p> <p>Centers of Disease Control and Prevention (CDC). (2024, March 15). Controlling Legionella in Potable Water Systems. Retrieved from Controlling Legionella: https://www.cdc.gov/control-legionella/php/toolkit/potable-water-systems-module.html#cdc_generic_section_15-resources</p>		