

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 02/26/2026
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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to provide a written notice of the reason for a facility-initiated transfer or bed hold to the resident or the resident's representative, for 1 (#74) of 15 sampled residents. Findings include: Review of resident #74's electronic medical record showed a discharge date of 12/28/25 to a local hospital. There were no transfer or bed hold notices in resident #74's electronic medical record. Resident #74 did not return to the facility following the transfer on 12/28/25. During an interview on 2/26/26 at 10:12 a.m., staff member X stated residents who transferred to the hospital for urgent evaluation would sign a bed hold and transfer notice form. Staff member X stated the nurse who was transferring the resident to the hospital would fill it out. Staff member X stated she did not know if a form was filled out for resident #74. During an interview on 2/26/26 at 10:21 a.m., staff member Y stated that residents who transferred from the facility signed a transfer notice and a bed hold notice form. Staff member Y stated the 100 wing had residents coming and going a lot because it was a rehab wing. Staff member Y stated nurses would assist the resident to sign the form if they could not. A request was made on 2/25/26 at 10:50 a.m. for resident #74's transfer and bed hold notice. The facility provided a document which showed, There is no bed hold present for [Resident #74]'s transfer dated 12/28/25. Review of a facility document, titled Discharge or Transfer, revised 8/30/25, showed: .1. The facility must provide the resident, the resident's representative, with a written notice at least 30 days before the resident is transferred or discharged, except when: c. The resident's urgent medical needs require an immediate transfer. 2. The written notice must include: a. The reason for transfer or discharge; b. The effective date of transfer or discharge; c. The location to which the resident is being transferred or discharged. 3. A copy of the notice shall be maintained in the resident's clinical record. Review of a facility document, titled Bed-Hold, revised 9/9/25, showed: . The facility issues two notices related to bed-hold policies. The notices will be provided in writing in a manner that resident/representative understands: a. First notice is given well in advance of any transfer. b. The second notice is provided to the resident, and if applicable the resident's advocate, at the time of the transfer, or in cases of emergency transfer, within 24 hours. [sic]</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 275044	If continuation sheet Page 1 of 4

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and record review, the facility failed to provide ADL assistance to a resident who required staff assistance with bathing, for 1 (#42) of 15 sampled residents. The deficient practice resulted in a resident feeling unclean. Findings include: During an interview on 2/24/26 at 8:55 a.m., resident #42 stated she had requested a shower twice a week on Tuesday and Friday. Resident #42 stated she very rarely received two showers a week. Resident #42 stated she did not feel clean due to the lack of showers provided. During an interview on 2/26/26 at 8:25 a.m., staff member L stated a bath aide was scheduled later in the morning to complete resident showers. Staff member L stated she tried to get some resident showers completed before the bath aide arrived to begin their shift. She stated that if a resident refused a shower, staff would re-approach the resident later and extend the offer again. Staff member L stated that if a resident refused a shower after a second attempt, she would report the refusal to the nurse, and the resident would sign a shower refusal form. Staff member L stated she was not sure if residents scheduled for the evening showers had been completed. Staff member L stated residents who were scheduled for evening showers often asked for a shower the following day, after their scheduled shower. During an interview on 2/26/26 at 9:15 a.m., staff member E stated she went by a list at the nurse's station to identify what residents were scheduled for a shower during the week. Staff member E stated if a resident refused a shower, she would ask again later or try on a different day. During an observation and interview on 2/26/26 at 9:30 a.m., staff member G stated if a resident refused to take a shower, she would have a different CNA offer the resident a shower. Staff member G stated if the resident continued to refuse a shower, a refusal sheet would be completed, and the resident would sign the form. Staff member G stated the shower refusal forms were located at the nursing station in a notebook. When checked, there was one shower refusal form observed in the notebook. Review of resident #42's care plan, dated 1/21/26, showed the resident was dependent on staff for bathing, and this was with the assistance of one staff member. Review of resident #42's bathing records, dated 12/1/25 through 2/26/26, showed the resident was scheduled to receive showers on Tuesday and Friday each week. Resident #42 did not receive a scheduled shower on 12/5/25, 1/6/26, 1/20/26, 2/3/26, 2/10/26, 2/13/26, and 2/17/26. Resident #42 had 24 opportunities for a shower and received 17 showers during the months of December 2025, January 2026, and February 2026. Based on resident #42's electronic medical record, the resident went without a shower for more than six days, four times, and one time, with 13 days between showers from December 2025 through February 2026. The documents supported the resident's claim of not receiving the preferred showers two times a week. Review of a facility document titled Activities of Daily Living, dated 9/8/25, showed: POLICY Residents receive assistance with activities of daily living (ADLs) based on their individual needs, preferences, and care plan goals. Staff provide support to maintain or improve the Resident's ability to perform ADLs and prevent avoidable decline. Any change in a resident's ability to perform ADLs is documented and reported to the licensed nurse for evaluation and care plan review .2. Staff help with the following ADLs as needed and in accordance with the Resident's care plan: 1. Hygiene: Bathing, dressing, grooming, oral care .4. Documentation and Reporting. ADL assistance and resident response are documented in the medical record .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview and record review the facility failed to provide a medication to meet the needs of 1 (#60) of 15 sampled residents. The failure to provide medication in a timely manner could prolong illness of Covid-19. Review of resident #60's physician note, dated 2/9/26, showed resident #60 had a chronic illness and was being treated with chemotherapy for metastatic cancer. Review of resident #60's nursing progress note, dated 2/21/26, at 5:04 p.m., showed that resident #60 tested positive for COVID-19. The physician ordered Molnupiravir (an oral antiviral medication for treating mild-to-moderate Covid-19 in high-risk, non-hospitalized patients) to treat resident #60's COVID-19. Review of resident #60's nursing progress note, dated 2/22/26, at 5:51 p.m., showed that Molnupiravir (medication) to treat COVID-19 was supposed to be delivered on Monday (2/23/26), in the morning. Review of resident #60's nursing progress note, dated 2/23/26 at 3:52 p.m., showed the Molnupiravir had not been delivered from the pharmacy. Review of resident #60's nursing progress note, dated 2/23/26 at 11:07 p.m., showed that Molnupiravir was administered to the resident, since it had just arrived from the pharmacy. It was identified that resident #60 had an acute illness, and the treatment was delayed for two days. During an interview on 2/26/26 at 10:23 a.m., staff member B said the prescription medication was delivered from a pharmacy out of state. Staff member B said there were times when a medication was not delivered timely. Staff member B said they received verbal confirmation that the medication was received for resident #60, but when she came back to work the next day, the medication had not been delivered. Staff member B said the facility did have an Omnicell, but they were still at the mercy of the pharmacy to restock medications. Staff member B said the medications could be shipped from a local satellite pharmacy, but this did not always occur. Staff member B said resident #60 was a prime example of not receiving medication to treat COVID-19 in a timely. Review of the facility policy titled Pharmacy Services, with a revision date of 9/16/25, showed: 2. The pharmacy collaborates with the facility to assure that medications are requested, received and administered in a timely manner as ordered by the authorized prescriber (in accordance with state requirements) b. Provide routine and emergency pharmacy services 24 hours a day, 7 days a week .FACT SHEET FOR HEALTHCARE PROVIDERS: EMERGENCY USE AUTHORIZATION FOR LAGEVRIO™ (molnupiravir) CAPSULES LAGEVRIO™ (molnupiravir) capsules, for oral use Original EUA Authorized Date: 12/23/2021 Revised EUA Authorized Date: 06/2024 Treatment of adults with mild-to-moderate COVID-19 who are at high risk for progression to severe COVID-19, including hospitalization or death and for whom alternative COVID-19 treatment options approved or authorized by FDA are not accessible or clinically appropriate</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility's kitchen staff failed to handle food in a clean and sanitary manner during meal service to prevent potential contamination. These deficient practices were observed in the food preparation area during meal service and resulted in unsanitary conditions in the kitchen. These failures may affect any resident who received food from the kitchen when sanitation practices were not upheld. Findings include: During an observation on 2/23/26 at 1:13 p.m., during a COVID-19 outbreak at the facility, two dietary staff members, P and J, were observed to be in the food preparation area, and neither was wearing an infection control face mask. During an observation on 2/24/26 at 8:20 a.m., during breakfast meal service: Staff member Q was assembling the resident's breakfast trays with gloved hands. Staff member Q picked up trays and tray cards, then touched the food racks with gloved hands. Staff member Q then used her contaminated gloved hands to place her hand, in a cupped position, over the top of the open juice glasses. The staff member moved from clean to contaminated tasks without changing her gloves or washing/sanitizing her hands. Staff member K was not wearing gloves when observed. Staff member K was grabbing the link sausages with her bare hands, cutting the sausages, and placing them on the plates, which were to be served to the residents. Staff member K grabbed muffins with her bare hands and placed them on the plates, then moved eggs from one side of a plate to another with her bare hands to make room for the rest of the food on the plate. Staff member K then placed her fingers on the inside of the cereal bowls after touching the food and plates. She did not wash or sanitize her hands or put on gloves. Staff member K also touched the plate surfaces with her hands and fingers, where food would be placed before being served to the residents. Staff member K did not follow infection control precautions during the meal service tasks. During an interview on 2/25/26 at 11:44 a.m., staff member D said the kitchen staff should never touch the food with their bare hands. During an observation on 2/25/26 at 11:47 a.m., during lunch service, the following was observed: Staff member DD was observed cutting pizza, then placing the pizza on the resident's plate, with his bare hands. Staff member DD was observed scraping beans out of the serving spoon, then moving the beans around on the plate with his bare hands. Staff member DD placed buns on the resident's plate with his bare hands. Staff member DD did not follow infection control precautions during the meal tasks. Staff member K cut a sandwich, then placed the sandwich onto the resident's plate with her bare hands, not using proper infection control precautions.</p>		