STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275044	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Ascension Transitional Care of Cascadia	2475 Winne Ave Helena, MT 59601

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure medications were not left at the bedside for resident self-administration without a physician order and safety assessment for 1 (#42) of 9 sampled residents. The failure placed the resident at risk for choking, aspiration, and medication errors. Findings include: During an observation on 3/22/26 at 9:45 a.m., resident #42 was lying in a recliner in her room. Resident #42 was observed to have neuromuscular spasticity of the bilateral upper extremities, weak vocal quality, a slowed speech pattern, and generalized neuromuscular weakness. Seven assorted colored and sized capsules were observed in a medicine cup on the table in resident #42's room. The medications were accessible to the resident without supervision.During an interview on 3/22/26 at 10:33 a.m., staff member E stated she went into resident #42's room earlier and left the medications at the bedside as the resident was in the shower. Staff member E stated that resident #42 probably did not have a physician's order for self-administration of medications.During an interview on 3/23/26 at 9:45 a.m., staff member B stated medications should not be left at the bedside unless an order and assessment supporting self-administration of medications was completed and in place. Staff member B stated that resident #42 did not have a medication self-administration order and stated she would educate staff member E.Review of resident #42's electronic health record showed diagnoses including oropharyngeal dysphagia, dysarthria, and anarthria (neuromuscular weakness affecting speech and swallowing), and conversion disorder with motor symptoms (involuntary neurologic motor symptoms).Review of resident #42's electronic health record showed no self-administration safety assessment or physician order for self-administration of medications.Review of resident #42's speech therapy note, dated 1/21/26 at 3:46 p.m., showed, Ptnt is permitted to have bread. Ptnt is on a regular diet. Her preference is for rye bread. [sic]No additional speech therapy notes or swallow evaluations were located in resident #42's electronic medical record to show the resident was safely able to swallow or self-administer medications.A written request for resident #42's medication self-administration safety assessment, speech therapy evaluation, and physician order for self-administration of medications was provided to the facility on 3/23/26. No documentation was provided by the end of the survey.

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 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 provide a clean, sanitary, and homelike environment for 2 (#s 1 and 13) of 9 sampled residents. The failure placed residents at risk for exposure to unsanitary environmental conditions and diminished quality of life. Findings include: During an observation and interview on 3/23/26 at 1:05 p.m., resident #1's room was observed to have soiled window surfaces, visibly dirty windowsills, a paper wrapper and medicine cup on the floor near the trash can, and wall surfaces with holes, cracks, and missing paint. Resident #1 stated, They keep telling me this is my home, but my home wouldn't look like this . I have lived here two years, and the window curtains and privacy curtains have not been washed once since I have been here . When I asked the housekeepers about cleaning them, they told me they can't take either of them down for cleaning because of privacy concerns. They can take them down; it would only be temporary . Everyone has some excuses. Those (privacy curtains) are touched by everyone . They don't clean well. Yesterday I saw the housekeeper take a paper towel from the wall dispenser, wet it with some water in the sink, and wipe the mirror with it, and they call that cleaning . It's not sanitary. The place doesn't even smell clean . Look at my walls, no one seems to care that there are holes in the wall and missing paint and cracks everywhere . The windowsills are filthy, and the windows are too . They come in and do a little sweep and wipe, but definitely not every day, and it needs more than just a quick sweep and wipe. I don't think they have ever deep cleaned my room, like move the furniture and bed and stuff, never!During an observation and interview on 3/23/26 at 3:05 p.m., resident #13's room did not appear to have received basic daily cleaning. Dust and debris were observed under the bed, under the heat register, and on the dresser. A crumpled napkin was observed on the floor near the base of the bed. The trash can was overflowing. A discarded glove and a gown tie were observed on the floor near the trash can. Resident #13 stated, No one came in here to clean at all yesterday or today.During an interview on 3/22/26 at 1:31 p.m., staff member L stated no deep cleaning was being completed, and as many rooms as possible were being swept or mopped daily. Staff member L stated that housekeeping staff work until approximately 2:30 to 3:00 p.m., five days per week. Staff member L stated, We have one housekeeper per floor, and we can only do so much. I have 47 residents up here. It's too much. We don't have time to deep clean anything. Staff member L stated the CNAs cleaned, as needed, after housekeeping left for the day.During an interview on 3/23/26 at 9:05 a.m., staff member G stated, Every room gets deep cleaned every day . We have two housekeepers and myself . Well, downstairs rooms get deep cleaned every day, and upstairs the deep cleaning is done weekly.During an interview on 3/23/26 at 11:15 a.m., staff member G stated deep cleaning of resident rooms would take approximately 45 minutes to an hour for each room, and daily room cleaning typically would take 15 minutes or less. Staff member G stated, Some rooms don't take long because they don't really move around in there much, so we can do a quick sweep or mop, and that's all. Staff member G further stated, I have been here a year, and I don't even know if the (window and privacy) curtains are removable.During an interview on 3/23/26 at 3:50 p.m., staff member A stated there are three housekeepers because staff member G had only very minimal additional responsibilities. Staff member A stated staff member G would not know how often deep cleaning was completed, as she is new to her role. Staff member A stated that two rooms on each floor are deep-cleaned every day.During an interview on 3/24/26 at 8:50 a.m., staff member G stated, I am sorry you misunderstood me, and stated the facility was working on a deep cleaning schedule, which should occur monthly for every resident room. Staff member G stated she helped the housekeepers as able but was also responsible for overseeing laundry, ordering supplies, completing spreadsheets, and attending meetings. Staff member G stated she usually cleaned the dining room, public entrance areas, and the nurse's station every morning she was working, and then focused on her supervisory tasks unless there was a call-off or other fill-in staff need. Staff member G stated the housekeepers were (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for cleaning on their assigned hall/floor; one housekeeper per floor.During an interview and record review on 3/24/26 at 9:30 a.m., staff member A stated, This is the deep clean log. What's the difference between a log and a schedule? Anyone can check something off. Resident #1's room was shown on the schedule for deep clean on 3/16/26, and resident #13's room was shown on the schedule for deep clean on 3/22/26.Review of QAPI meeting minutes for May through December 2025 showed the previous housekeeping manager was planning to start a privacy curtain cleaning rotation in June of 2025.A request was made for privacy curtain cleaning rotation documentation on 3/24/26. No documentation was provided by the end of the survey.Review of a facility document titled Position Description, undated, showed: Position Title: Housekeeping Manager . Essential Functions . - Manages team of housekeeping employees. - Ensures overall cleanliness and comfort of facility. - Assigns workers their duties and evaluates conformance to prescribed standards of cleanliness. - Schedules housekeeping employees based on facility census and other operating constraints. - Provides orientation, trains, evaluates of housekeeping employees. - Inventories stock to ensure adequate supplies and reports any ordering needs to Central Supply. - Issues supplies and equipment to workers. - Inspects and evaluates physical condition of establishment and submits recommendations for painting, repairs, and furnishings to management. - Investigates complaints regarding housekeeping service and equipment and takes corrective action. - Manages punctuality and regular attendance for all scheduled housekeeping shifts . [sic]Review of a facility document titled Complete Room Cleaning, undated, showed: PURPOSE: The Complete Room Cleaning Schedule ensures that each resident room is discharge-cleaned on a monthly basis 3.g. Windows - clean window tracks and check curtains. Report any soiled or damaged curtains to housekeeping supervisor. [sic]

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician ordered services were provided in accordance with professional standards for 1 (#99) of 9 sampled residents. The failure resulted in the resident not receiving ordered physical therapy services and placed the resident at risk for decline in mobility, strength, and functional status. Findings include:During an interview on 3/23/26 at 10:12 a.m., staff member D stated that when physical therapy orders were included in a resident's admission orders, the admitting staff member would forward a copy to the therapy department, and the physical therapist would complete the initial therapy assessment. Staff member D stated resident #99's initial therapy order may have been missed (not processed) by the admitting nurse or not forwarded to therapy; therefore, therapy staff would be unaware that services were ordered.During an interview on 3/23/26 at 10:25 a.m., staff member H stated that when a new therapy order was received, the initial evaluation would be completed by the physical therapist within a couple of days, and treatments would then be completed by the physical therapy assistants, in accordance with the treatment plan. Staff member H stated that resident #99 did not receive the ordered services, and he did not know how it occurred.During a phone interview on 3/23/26 at 1:15 p.m., NF1 stated resident #99 was admitted on [DATE] with therapy ordered for the resident, but the therapy was not provided during his stay. NF1 stated resident #99 was transferred to an assisted living facility, per her request, on 2/10/26.Review of resident #99's admission orders, dated 12/23/25, showed a physician's order for physical therapy services to evaluate and treat. The admission orders were signed off by NF2 on 1/1/26.Review of resident #99's admission MDS with an ARD of 12/29/25, showed none of the above in Section O0390, Therapy Services.Review of a facility document titled Census Details Report, dated 3/23/26, showed resident #99 was not enrolled in therapy services at any time during his stay.Review of National Council of State Boards of Nursing professional standards for nursing, located at www.ncsbn.org, accessed on 3/26/26, showed, Nurses are responsible for implementing orders for patient care unless they have reason to believe the order is inaccurate, not properly authorized, or harmful to the patient.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure a timely, comprehensive interdisciplinary team (IDT) post-fall assessment, including root cause analysis, implementation of effective interventions, and care plan updates, was completed for avoidable falls, for 1 (#19) of 9 sampled residents. The failure resulted in the resident experiencing additional falls, and the resident had a major injury and was hospitalized . Findings include:During a telephone interview on 3/23/26 at 1:40 p.m., NF4 stated resident #19 had been declining for the past couple of months, with increased confusion, weight loss, agitation, and right hip and leg pain. NF4 stated resident #19 was transferred to the facility post-hospitalization with an iliac fracture after being found outside of her home in eight-degree weather. NF4 stated resident #19 continued to decline at the facility and fell once, then contracted COVID-19, and fell two additional times. NF4 stated resident #19 was placed on hospice at the hospital and passed away on 3/3/26.During an interview on 3/23/26 at 3:15 p.m., staff member B stated the facility completed an IDT post-fall assessment, typically within 24 hours of a resident's fall. The IDT meeting identified root causes for the falls and determined interventions to prevent additional falls. The resident's care plan was updated as needed. The IDT meetings were part of the morning meeting and therefore occurred every weekday. Staff member B stated the IDT meetings for resident #19 did not occur in a timely manner, stating, There was a lot going on here at that time.During an interview on 3/23/26 at 3:50 p.m., staff member A stated resident #19 had experienced three falls after her initial hospitalization, as she was declining mentally and physically prior to and while at the facility, and the hospital and radiology notes from 3/2/26 showed suspected bone malignancy.Review of resident #19's hospital discharge note, dated 2/6/26, showed diagnoses including osteopenia, degenerative changes, altered mental status, dementia, cognitive decline, right iliac crest fracture, weight loss, and lethargy. The discharge note also showed, Her cognitive decline has been present over months, however it sounds like it has progressed rather rapidly over the past month.Review of resident #19's nursing progress notes showed the resident experienced a total of three falls, and the notes showed: -On 2/23/26, resident #19 was observed attempting to park her wheeled walker and fell on her right knee and hip. No injuries were sustained at that time.-On 2/25/26, resident #19 was placed on palliative care services as recommended on discharge from the hospital on 2/6/26.-On 2/26/26, resident #19 tested positive for COVID-19.-On 3/1/26, resident #19 sustained an unwitnessed fall, resulting in bruising to the right elbow and right hip.-On 3/2/26, resident #19 sustained an unwitnessed fall with facial laceration and hematoma to the left brow region, skin tear to the left elbow, decreased level of consciousness, and the resident was transported to the hospital with emergency services.Review of resident #19's post-fall IDT note for the 2/23/26 fall, which was not dated until 3/5/26, showed: RCA: (Resident #19) attempted to park her walker without locking the brakes, her short-term memory contributing to the lack of completion of this safety step, which then resulted in the walker rolling away and causing the loss of balance and the fall. Parking the walker near the opposite bed created a situation in which this required her to step backwards, thus exceeding her functional abilities. Interventions: More frequent visual checks, consistent cuing and reinforcement for safe walker handling, evaluate walker for proper fit/function, OT/PT to continue with therapy with additional focus on fall prevention. [sic]Review of resident #19's electronic health record showed no evidence of the updated fall interventions implemented following the 2/23/26 fall, and the interventions identified by the IDT on 3/5/26 were not identified until after the resident was transferred to the hospital on 3/2/26.Review of resident #19's care plan, dated 2/6/26, and last updated on 3/9/26, showed no updated fall interventions between 2/6/26 and 3/9/26, when all care plan entries were cancelled due to resident #19's death. The facility failed to document and implement the interventions for falls on the resident's care plan, in an attempt to prevent future falls. The resident continued to have recurring falls and paired with her recent decline (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and Covid-19 illness, her risk was greater, highlighting the need for closer monitoring and oversight. Review of a facility document titled Fall Response & Management, last revised on 8/21/25, showed: PROCEDURES: . 5. Fall incident(s) will be evaluated to determine probable causal factors, including but not limited to environmental, medical, supervision, and/or assistive device needed.6. The Resident's care plan will be reviewed and updated following a fall incident, incorporating individualized measures to eliminate (if possible) or minimize risk of recurrence.7. The Interdisciplinary team (IDT) will review the fall incident and place intervention(s). The IDT will review and revise the care plan as needed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to develop and implement an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program. The facility identified multiple Performance Improvement Projects (PIPs); however, failed to implement, monitor, and sustain effective corrective actions. The failure resulted in ongoing quality of care and service concerns without resolution and placed all residents at risk for continued substandard care and negative outcomes. Findings include:During an interview on 3/23/26 at 2:30 p.m., staff member A stated the facility had a QAPI meeting system wherein each department manager would identify departmental updates and performance improvement projects for their department on a shared PowerPoint, which was then presented at the quarterly QAPI meetings. The department managers reported the progress and results in future meetings as appropriate. Staff member A stated each department had multiple PIPs in the past year. Staff member A stated QAPI meetings were held both quarterly and as needed, such as an Ad Hoc QAPI meeting after surveys.During an interview on 3/24/26 at 10:15 a.m., staff member K stated QAPI meetings were primarily informational and were not focused on problem-solving or process improvement. Staff member K stated the meetings consisted of reviewing departmental activities and did not consistently include follow-up on previously identified concerns. Staff member K stated she and staff member C had been discussing revising the format of the QAPI meetings to a more process-driven template, including identifying system failures, assigning responsibility, and establishing action items. Staff member K stated the facility had experienced ongoing system failures over the past year and QAPI meetings should occur more frequently to address new concerns and monitor progress of previously identified PIPs. Staff member K stated the QAPI committee .definitely needs to be more than it has been.Review of the facility's quarterly QAPI meetings in 2025 showed multiple quality concerns were identified, including infection control practices, housekeeping/environmental issues, care plans, pain management, and skin and wounds. The meeting documentation lacked evidence of the root cause being discussed or analyzed, lacked clearly defined action plans, and lacked documentation of the monitoring effectiveness or sustained improvement for identified issues.Review of the facility's PIP documentation for 2025 showed multiple projects were initiated; however, documentation did not include measurable goals, timelines for completion, or evidence of ongoing evaluation of interventions. Several issues were repeatedly identified across multiple meetings without documented resolution or progress.Review of a facility document titled Quality Assurance and Performance Improvement (QAPI), revision date 11/28/19, showed: . The committee meets at least monthly to:- a. Identify performance improvement opportunities through tracking and trending of data that necessitate quality assessment and assurance activities against state and national benchmarks;- b. Establish goals, thresholds, and performance indicators to advance quality;- c. Systematically analyze underlying causes of quality deficiencies;- d. Prioritize action plans through high volume, high risk, problem prone, and near miss review;- e. Develop appropriate plans of action to impact improvements opportunities;- f. Establish and implement process improvement strategies; .- i. Evaluate effectiveness of the process improvement activities, revise to achieve desired outcomes, monitor for sustained results.

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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 implement appropriate infection prevention and control practices, including hand hygiene, transmission-based precautions, and personal protective equipment (PPE), for 1 (#42) of 9 sampled residents. The failure placed residents, staff, and visitors at risk for transmission of COVID-19 and other infectious diseases. Findings include:During an observation on 3/22/26 at 8:58 a.m., a sign on the facility's public entrance door showed the facility had active resident cases of COVID-19 in the building.During an observation on 3/22/26 at 9:34 a.m., a sign was observed on resident #42's room, showing the resident was on Enhanced Droplet Precautions. The sign showed the use of an N95 face mask, gown, gloves, and eye protection was required. A PPE supply cart was observed outside of resident #42's room, which contained eye protection, masks, and gloves in the first drawer, and the second and third drawers were empty. The cart did not contain isolation gowns. Staff member E was observed entering and exiting resident #42's room wearing a face mask. No gown, gloves, or eye protection were observed in use by staff member E. Staff member E then returned to the medication cart to retrieve additional medications and then entered another resident's room wearing the same mask. No hand hygiene was observed at any time during the observation period. Staff member E failed to follow safe infection control precautions when completing tasks for the resident on Enhanced Droplet Precautions, and then went into another resident's room, increasing the risk of the spread of infection(s).During an observation on 3/22/26 at 9:40 a.m., no PPE was observed inside resident #42's room or in the trash receptacle inside the room.During an observation on 3/22/26 at 10:20 a.m., staff members E and F were observed entering resident #42's room wearing face masks. Both staff members exited the room several minutes later. No additional PPE was observed in use by either staff member E or F. No isolation gowns were observed in the PPE supply cart located outside the room. No hand hygiene was observed after exiting the room.During an observation and interview on 3/22/26 at 10:29 a.m., no used gowns were observed in the trash receptacle inside resident #42's room, and no gowns were observed on the PPE supply cart located outside the room. Resident #42 stated she was in isolation for 14 days after testing positive for COVID-19. Resident #42 stated the staff, don't always wear gowns or all that other isolation gear, maybe because I only have a couple of more days left on isolation.During an interview on 3/22/26 at 11:00 a.m., staff member E stated, I think we (staff) should be wearing PPE in (resident #42's) room. I guess I should have had it on, but I just went in quickly and dropped off her meds. She was in the shower.During an interview on 3/22/26 at 12:45 p.m., staff member B stated the facility had been experiencing a COVID-19 outbreak since 2/17/26.During an observation on 3/23/26 at 9:44 a.m., staff member F was observed standing in front of resident #42's door, reading the Enhanced Droplet Precaution sign. Staff member F was holding goggles in her hand and reading the instructions for PPE. Staff member F stated, It's been quite some time since we had training.During an interview on 3/23/26 at 1:19 p.m., staff member I stated she had been working at the facility for approximately 18 months through a contracted agency. Staff member I stated she had not received updated training on transmission-based precautions through her (contracted) agency since 2023. She stated she did not receive updated training by the facility. Staff member I stated, for Enhanced Droplet Precautions, eye protection was only required if there was a likelihood of splash contact. Staff member I also stated she did not understand when Enhanced Barrier Precautions would be used.A request was made on 3/23/26 for Enhanced Droplet Precautions and Enhanced Barrier Precautions staff education. The requested documentation was not provided by the end of the survey.Review of a facility document titled Special Droplet & Contact Precautions, dated 9/13/25, showed, This facility implements Special Droplet and Contact Precautions when a resident presents with signs or symptoms of a respiratory illness (until confirmation of diagnosis), or is diagnosed with a transmissible condition requiring the use of a NIOSH-approved particulate respirator (N95 or higher), gown, gloves, and eye protection (e.g., goggles (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or a face shield that covers the front and sides of the face), such as COVID-19.Review of Centers for Disease Control and Prevention (CDC) guidance located at https://www.cdc.gov/COVID, accessed on 3/26/26, showed, Infection Control Guidance: SARS-CoV-2 for Health Care Providers . Enhanced Droplet Precautions for COVID-19 are infection control measures used to prevent the spread of particles from coughing, talking, or touching contaminated surfaces. These protocols require hand hygiene, a surgical mask, eye protection, a gown, and gloves when in the patient's room, with all PPE removed upon exiting.