

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/16/2026
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)		
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to implement and operationalize an effective grievance process and failed to thoroughly investigate, document, track, and resolve grievances, including failing to provide a written grievance decision upon request, for 1 (#10) of 11 sampled residents. The facility also failed to prominently post and include within the facility grievance policy the required contact information for the designated grievance official (name, business mailing address, business email, and business telephone number), which may affect any resident wishing to file a grievance at the facility. These failures resulted in a family member not receiving a timely written resolution to four grievances submitted to the facility. Findings include: Observations on 7/15/26 at 10:02 a.m. and on 7/16/26 at 12:30 p.m. revealed the facility did not prominently post the designated grievance official's required contact information. The posted information did not identify the grievance official by name and did not include a business mailing address, business email address, or business telephone number. During an interview on 7/16/26 at 1:22 p.m., NF1 stated she had submitted four written grievances to the facility on 6/26/26 regarding resident #10. NF1 stated she requested a written response on 7/6/26. NF1 said staff member A asked for her email address on 7/6/26 and informed her he was working on the grievances; however, as of the interview date, she had not received a written response or resolution. NF1 stated she continued to desire a written response from the facility. During an interview on 7/16/26 at 1:34 p.m., staff member A said he received the four grievances dated 6/26/26 from a former employee and was asked to address them. Staff member A said NF1 expected a response to the grievance(s) by the end of the week and admitted he had not yet responded, although it had been over two weeks from receipt of the grievance(s). Staff member A stated grievances should be addressed as soon as possible, although some become delayed, estimating they should generally be addressed within a week or two. Staff member A identified himself as the facility's grievance official but stated he did not know whether the grievance official's information was posted in the facility, stating, I don't know if the grievance officer is posted or not. Review of the facility's grievance log showed no documentation of the four grievances submitted by NF1 on 6/26/26 regarding resident #10. A request was made for NF1's four grievances submitted on 6/26/26 by NF1 on 7/16/26 at 12:46 p.m. Review of the grievance documents provided by the facility included four grievance forms with attached narratives describing the concerns. The records lacked evidence that grievances were processed according to the facility's grievance process, and showed: - No department or responsible staff member was assigned.- The section identifying What occurred? was blank.- The section documenting When and where did the event occur? was blank.- The section identifying a person with knowledge of the event was blank.- The section summarizing interviews conducted during the investigation was blank.- Additionally, the second page of the document titled Complaint/Grievance Follow-Up was entirely blank.- There was (continued on next page)		

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: 275044	Facility ID: 275044 If continuation sheet Page 1 of 7

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	no documentation demonstrating the facility investigated the allegations, completed follow-up activities, reached findings, implemented corrective actions, communicated a resolution, or issued a written grievance decision. Review of the facility's policy titled Grievance Process, revised on 8/29/25 showed, Policy, .the Grievance program is utilized to address the concerns of Residents, family members and visitors and the facility should make prompt efforts to resolve grievances. Definitions, prompt efforts to resolve refers to a facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. Procedure.3. The facility provides (or post in a prominent location), information on:.b. The contact information of the grievance official with whom grievance can be filed.c. A reasonable expected time frame for completing the review of the grievance.d. The right to obtain a written decision regarding his/her grievance.7. The Nursing Home Administrator/Designee is responsible for overseeing the grievance process; including receiving, tracking, and conclusion/resolution.8. The facility ensures that all written grievance decisions include:a. The date the grievance was received,b. A summary statement of the Resident's grievance,c. The steps taken to investigate the grievance,d. A statement as to whether the grievance was confirmed or not confirmed,e. Any corrective action/solution taken or to be taken by the facility to resolve the grievance,f. The date the written decision was issued. Responsibility of the Nursing Home Administrator and/or Designee:1. Overseeing the facility's grievance program2. Ensuring that all grievance reports have been reviewed and addressed in a timely and appropriate manner and that concerned individuals feel that some type of resolution has been communicated, achieved, and maintained. [sic]Review of the policy further showed it did not identify the designated grievance official by name and did not include the required business mailing address, business email address, or business telephone number for contacting the grievance official.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the provision of pharmaceutical services to ensure ordered medications were available which resulted in missed doses of prescribed pain medications, interruption in pain management, and delayed care, and resident medications were not acquired, received, dispensed and or administered as needed or ordered by the physician, for 2 (#s 2 and 3) of 11 sampled residents. This failure contributed to the ongoing risk for resident #2, who had a diagnosis of Stage IV cancer and required high-dose pain medication(s) for pain relief, and this increased the risk for uncontrolled symptoms of pain. Findings include: 1. During an interview on 7/15/26 at 4:01 p.m., staff member B said resident #2 was readmitted to the facility on [DATE] following a hospitalization. Staff member B explained that by the time the facility pharmacy received the readmission medication orders for the resident, the pharmacy's ordering cutoff time had passed. Most of the medication orders were submitted the following day; however, the narcotic prescriptions required physician confirmation before processing. Staff member B stated she was addressing resident #2's lack of narcotic pain medication since 6:00 a.m. that morning, and she had attempted to transfer the resident to the emergency department for pain control. Staff member B further stated resident #2 had exhausted her supply of hydromorphone, and the prescribed fentanyl patches were not received from the pharmacy yet. During an interview on 7/15/26 at 4:34 p.m., resident #2 reported she was experiencing pain. Resident #2 revealed she had Stage IV cancer and was recently hospitalized. Resident #2 stated her pain medication regimen had been changed during the hospitalization. When she was readmitted to the facility, she was informed the medications were not delivered from the pharmacy. Resident #2 said stated she had been without her pain medication and described it as though, My nerve endings are on fire. During an interview on 7/16/26 at 9:00 a.m., staff member I stated hospital discharge prescriptions for controlled substances were transmitted directly to the pharmacy. Staff member I explained that when urgently needed medications are unavailable, staff may contact the pharmacy, and if orders have been received before 3:30 p.m., they can obtain an access code to retrieve pain medications from the Omnicell (medication dispensing machine). Review of resident #2's hospital discharge orders dated 7/13/26 showed resident #2 was discharged with the following prescribed pain medications:- Gabapentin 300 mg oral capsule 3 times a day.- Hydromorphone 12 mg by mouth every 3 hours.- Fentanyl transdermal patches totaling 300 mcg every 72 hours, last placed on 7/11/26. Review of resident #2's medication administration record for July 2026 showed,- Gabapentin 300 MG: five scheduled doses were coded as not available.- Hydromorphone 4 MG: four scheduled doses were coded as not available.- Fentanyl patches: scheduled dose on 7/14/26 coded as not available. Review of resident #2's minimum data set pain questionnaire, dated 7/13/26, showed the resident experienced pain that was present almost constantly. The assessment included documentation that the pain almost constantly affected the resident's sleep, constantly interfered with day-to-day activities, and was rated by the resident as a 9 on a 0-10 numeric pain scale with 10 being the worst. Review of resident #2's electronic health record showed:- admission Note, effective 7/13/26 at 4:19 p.m., admission Clinical Evaluation Completed: [AGE] year old female admitted back to facility from [Acute Hospital] today after having left knee fracture repaired. Resident is continued on Palliative Care with [Hospice Provider]. Resident has discharged with more Opioids on board for better pain management of Cancer diagnosis and recent fracture. [sic]- Health Status Note, effective 7/15/26 at 1:23 p.m., Received phone orders from (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on-call provider [Provider Name] to send rsdt to ER for pain management/control as rsdt has no pain meds in facility to administer d/t receiving none from the pharmacy and has had nothing for pain since the evening of 7/14/26. Rsdt also agree to go to ER for pain management/control as she is in pain. [sic]- Health Status Note, effective 7/15/26 at 2:43 p.m., EMTs arrived at facility and discussed going to ER with rsdt. EMTs told rsdt that ER would do nothing for her but administer her Tylenol and send her back. EMTs stated that they do not administer opioids and the ER would not administer opioids either. That transferring rsdt to ER would cause her more pain than good, and it would be best to keep rsdt here in facility and wait for pain medications to arrive here. Rsdt became tearful, still in pain, and did not know what to do. After a bit more discussion, rsdt decided to remain in facility if ER/EMTs were not going to do anything to help her. [Hospice Provider] and on-call providers are sending in a satellite Rx to local pharmacy to get narcotics filled and available at pharmacy. [sic]2. During an interview on 7/15/26 at 3:01 p.m., resident #3 stated she had gone without her prescribed gabapentin for several days and experienced pain in her feet. During an interview on 7/15/26 at 2:40 p.m., staff member F stated the facility often ran out of medications, and the Omnicell (medication dispensing machine) routinely did not have medications needed for residents. During an interview on 7/15/26 at 2:43 p.m., staff member G said residents had experienced delays in receiving medications and stated those delays had affected resident care. During an interview on 7/15/26 at 4:01 p.m., staff member B stated nurses assigned to the medication cart were responsible for reordering medications. Staff member B stated medication deliveries occurred on Tuesdays and Thursdays and explained medication ordering by the night shift was inconsistent and required day shift nurses to complete missed reorders. Staff member B stated, Pills are kind of a struggle. During an interview on 4/16/26 at 10:11 a.m., staff member A said medication delays had occurred following the contracted pharmacy's software conversion. Staff member A stated residents had missed or received medications late and said there were occasions when medications that were expected to be available in the Omnicell were not, because the Omnicell had not been restocked. Staff member A further stated the facility's corrective action for the medication issues included changing pharmacy providers because the pharmacy's performance had not improved despite discussion that had occurred approximately one to two months earlier. Staff member A mentioned available options for pharmacy contractors and stated he had one in mind specifically that he was going to contact. During an interview on 7/16/26 at 1:11 p.m., staff member H said medication refill requests could be completed by fax, telephone, or through the electronic medical record. Staff member H explained the pharmacy relied on facility staff to notify the pharmacy when Omnicell medications required replenishment outside of the scheduled restocking and stated par levels (number of medications stocked/available) could be adjusted when medications routinely ran short. Review of resident #3's pain assessments showed the resident reported a pain level of 5 prior to the administration of as needed acetaminophen on 7/8/26. Additional documented pain assessments on 7/9/26 showed pain ratings of 10 and 6 on a 0-10 numeric pain scale prior to as needed acetaminophen administration. Review of resident #3's care conference review, dated 7/13/26 at 11:30 a.m., showed in the comments section: [Resident #3] is a long-term resident at the facility. Pain/Discomfort: [Resident #3] reported no current pain or discomfort at the time of the visit. However, she stated that she was without her gabapentin for approximately one week beginning in early July due to a facility-related issue. She reported that the pain became so severe that she felt like she wanted to amputate her feet. I confirmed that a total of nine doses were missed. This concern will be relayed to the ADON for follow-up. [sic] Review of resident #3's medication administration record for July 2026 showed the resident missed nine scheduled doses of gabapentin between 7/6/26 and 7/9/26. Review of resident #3's electronic health record showed,- EMAR (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress note, effective 7/6/26 at 1:30 p.m., Gabapentin Oral Capsule 100 MG, give 2 capsules by mouth three times a day for neuropathy, was on order from the pharmacy.- EMAR progress note, effective 7/7/26 at 12:08 p.m., Gabapentin Oral Capsule 100 MG, give 2 capsules by mouth three times a day for neuropathy, was on order from the pharmacy.- EMAR progress note, effective 7/9/26 at 7:54 a.m., Effective Date: 07/09/2026 07:54 a.m., Gabapentin Oral Capsule 100 MG, Give 2 capsule by mouth three times a day for neuropathy.Medication not available, did not arrive from the pharmacy. Will call again today to find out where it is. Was told by [Provider Name] a new script was sent to pharmacy days ago.- EMAR Note, effective 7/9/26 at 11:37 a.m., Gabapentin Oral Capsule 100 MG, Give 2 capsules by mouth three times a day for neuropathy. This RN called pharmacy re medication. Pharmacist states that the provider sent in the wrong medication that the pharmacy does not carry. A message was sent to the main pharmacist asking if the medication could be changed to 2 (two) 100mg caps instead of what was ordered, they have not heard back from the pharmacist yet as to what to do, she said fax will also be sent to provider letting them know as well. So, still unable to pull any from omnicell as they cannot give me a code to pull because they do not have the accurate script also unable to administer any of this medication to rsdt as we have none [sic]- EMAR Note, effective 7/9/26 at 3:30 p.m., Rsdtd requested tylenol for foot pain, Rsdtd states her feet are very sore without having gabapentin for so long. [sic]Review of the facility's policy titled, Pharmacy Services, revised on 9/16/25, showed, Policy, This facility ensures the provision of pharmaceutical services through a contracted pharmacy to meet the medication-related needs of each resident. These services are delivered in accordance with 42 CFR S483.45, and applicable state laws. The facility collaborates with the pharmacy to ensure safe, timely, and compliant medication practices, including dispensing, .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to ensure residents received showers and assistance for their assessed needs and physician orders for 2 (#s 8 and 9) of 11 sampled residents. The deficient practice resulted in both residents going approximately 12 to 13 days without a shower. Resident #9 had a physician's order requiring a minimum of four showers per week due to colostomy care needs, and the lack of showering increased the risk of compromised personal hygiene and skin integrity concerns. Findings include: 1. During an interview on 7/15/26 at 10:33 a.m., staff member B said resident showers are generally scheduled for two times per week. During an interview on 7/15/26 at 11:46 a.m., resident #8 stated she was scheduled to receive showers two times per week. Resident #8 stated approximately two week earlier, she did not receive a shower for about two weeks because of staffing shortages. Review of the facility's shower schedule showed resident #8 was scheduled to receive showers on Thursday and Sunday. Review of resident #8's shower documentation for June and July 2026 showed missed scheduled showers on: 6/4/26- 6/18/26- 6/21/26- 6/25/26- 7/5/26. The documentation revealed resident #9 did not have a shower from 6/15/26 through 6/27/26, a period of 13 consecutive days, despite the established shower schedule. Resident #8's comprehensive care plan, last reviewed on 7/15/26, showed the resident required substantial to maximum assistance for bathing with the assistance of one staff member, showing the resident was dependent on staff for her care needs. 2. During an interview on 7/15/26 at 10:33 a.m., staff member B said some residents required more than the facility's routine shower schedule of two showers per week. Staff member B stated one resident had a physician order that required at least four showers per week. During an interview on 7/15/26 at 3:27 p.m., resident #9 said she preferred showers three times per week, and there were occasions when she did not receive them as often as she preferred. Resident #9 said she had a colostomy and this required more showers to maintain hygiene and care for the skin surrounding her stoma. Review of resident #9's comprehensive care plan, last reviewed on 6/30/26, showed she required set up assistance for bathing with the assistance of one staff member. Review of resident #9's physician orders showed an order dated 11/20/25 directing staff to provide the resident a minimum of four showers per week. Review of resident #9's shower documentation for June and July 2026 showed resident #9 missed showers on: 6/4/26- 6/8/26- 6/13/26- 6/18/26- 6/20/26- 6/22/26- 6/25/26- 6/27/26- 7/9/26- 7/11/26. The documentation further showed resident #9 did not receive a documented shower between 6/17/26 and 6/28/26, a period of 12 consecutive days, despite a physician's order requiring at least four showers each week. Review of the facility's policy 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. Procedure. 2. Staff help with the following ADLs as needed and in accordance with the Resident's care plan: I. Hygiene: Bathing . [sic]		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure nursing aides received performance evaluations that were completed and maintained, at least annually for 3 staff members (C, D, and E) of 3 employee files sampled. This resulted in the absence of documented assessments of employee performance, feedback, and opportunities to identify education or performance improvement needs. The deficient practice increased the risk that all residents receiving care from nurse aides could be affected by unrecognized performance deficits. Findings include: Review of staff member C's employee file showed the staff member was hired in 2024. The file contained no documented performance evaluations since the date of hire. Review of staff member D's employee file showed the staff member was hired in 2022. The file contained a blank performance review form, which was incomplete. There was no annual performance review in staff member D's file dating back to the staff member's hire. Review of staff member E's employee file showed the staff member was hired in February 2025. The file contained no documentation showing that a performance evaluation had been completed since the employee's hire. During an interview on 7/16/26 at 2:09 p.m., staff member A said the employee files did not contain performance evaluations because the previous employee responsible for the process and evaluations did not do them. Staff member A said the former employee was going to be placed on a performance improvement plan because the evaluations were not completed on an annual basis, but the employee resigned before that happened. Review of the facility's Employee Handbook, revised on 10/2025, showed, .Performance Evaluations, Performance evaluations are periodic supervisor appraisals of your job performance. Performance reviews are formal and in writing, .This documentation becomes a recorded part of the employment record.		