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 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Ascension Transitional Care of Cascadia	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49554 Based on interview and record review, the facility staff failed to respect a resident's rights by not following up with a request's request to be sent to the emergency room when the resident was not feeling well, and a visitor called the ambulance for the transfer to the acute care setting, for 1 (#11) of 30 sampled residents. Findings include: Review of a Facility-Reported Incident, submitted to the State Survey Agency on 1/1/25, showed resident #11 was not feeling well and requested to go to the hospital, claiming the facility staff refused to send her. Review of resident #11's nursing progress notes, dated 12/30/24 at 12:24 p.m., showed, Resident requested to go to Hospital this AM at approximately 9:30 am. Resident c/o not feeling well. [sic] During an interview on 1/15/25 at 6:24 p.m., staff member M stated, Resident #11 said she wasn't feeling well and wanted to go to the hospital. Her oxygen levels were low. Review of resident #11's nursing progress note entered on 12/30/24 at 3:28 p.m. showed, Ambulance was called by non facility home caregiver. Caregiver did not notify facility that she had/was going to call ambulance. Resident left by ambulance and transported to [hospital name] @ 1520. [sic] During an interview on 1/16/25 at 11:25 a.m., staff member B stated she was aware of the incident that happened on 12/30/24. Staff member B stated, The nurse that was on duty alerted me of the resident's condition. I was in the facility when the ambulance showed up to pick up the resident. Review of a facility document titled, Resident's Rights, undated, showed, .1. The resident has a right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the Facility. 4. The Resident has a right to be free of interference, coercion, discrimination, or reprisal from the Facility in exercising his or her rights and to be supported by the Facility in the exercise of those rights. 6. The Resident has the right to be informed of and participate in their treatment. [sic]

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

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 01/16/2025
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49554 Based on interview and record review, the facility failed to identify and report an allegation of neglect to the State Survey Agency, within 24 hours of the incident, for 1 (#11) of 30 sampled residents. Findings include: Review of a Facility-Reported Incident, submitted to the State Survey Agency on 1/1/25, showed resident #11 was not feeling well and requested to go to the hospital, claiming the facility staff neglected to send her. Review of resident #11's electronic medical record showed this incident occurred on 12/30/24. During an interview on 1/16/25 at 11:25 a.m., staff member B stated she was aware of the incident that occurred with resident #11 on 12/30/24. During an interview on 1/16/25 at 1:57 p.m., staff member A stated, I do the reporting in Bounds (electronic reporting system) and reported the incident to the state when we determined it might have been a reportable incident. During an interview on 1/16/25 at 2:03 p.m., staff member L stated, We received an anonymous complaint in our complaint portal on our website on 1/1/25. We then reported it to the state; that is why it was late. Review of the complaint submitted through the facility website was dated 12/30/24, and the complaint showed an outside caregiver submitted a complaint about a code of ethics violation involving facility staff, and resident #11. Review of company staff email communication showed, Will need to follow up within 24 hours. We need to make sure there's nothing here that's reportable. This email was sent to staff member A and L on 12/30/24 at 7:45 p.m. Although the two staff were aware of the event, neither reported the event timely. Review of a facility document titled, Abuse, with a revision date of 7/23/2019, showed, .17. Allegations of verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment, injuries of unknown source, exploitation, deprivation of goods and services by staff, and misappropriation of resident property are reported to the Executive Director IMMEDIATELY and the state agency . [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** 49554 Based on interviews and record reviews, a facility licensed staff member failed to provide services that met professional standards, by failing to monitor a resident's need for oxygen, and monitor the resident's need to transition to an acute care facility, for further assessment, for 1 (#11) of 30 sampled residents. The resident was treated for an illness at the acute care hospital. Findings include: During an interview on 1/13/25 at 4:09 p.m., resident #11 stated, . The facility staff let my issue go on too long before calling the hospital. My companion that day didn't like it and called an ambulance for me since I wasn't feeling well. I already spoke with APS about it, and I don't want to revisit the situation. During an interview on 1/13/25 at 4:12 p.m., NF1 stated, I don't think the facility staff took the resident's concerns seriously. Review of resident #11's progress notes written by staff member M, dated 12/30/24, are as follows: - 12/30/24 at 12:24 p.m., Resident requested to go to Hospital this AM at approximately 9:30 am. Resident c/o not feeling well. When asked she couldn't articulate what was wrong except that she didn't feel well. VSS 116/57, P83, O2 sat 71%, RR 18, T 98.4. Resident refused her morning medications except for Imburvica 420mg (she took). Called Dr [Name] and Dr stated to call [Name] and have her come and check her today. I called and had to leave a message. At this time resident is stable and comfortable. - 12/30/24 at 3:28 p.m., Ambulance was called by non-facility home caregiver. Caregiver did not notify facility that she had/was going to call ambulance. Resident left by ambulance and transported to [hospital name] @ 1520 (3:20 p.m.). - 12/30/24 at 4:18 p.m., tried to have resident use 2L oxygen for a few minutes. She took it off and checked O2 sat later at 10am at 91% RA and resident refused to keep oxygen on. [sic] During an interview on 1/15/25 at 6:24 p.m., staff member M stated, . resident #11's O2 levels were bouncing between 88 and 92%. Since her sats looked low, I called the doctor. The doctor told me to call her nurse practitioner, and she would be in to see her that day. I didn't get through to the nurse practitioner, so I left a message. Resident #11's non-facility caregiver came to the desk around 3:30 p.m. and asked why we didn't send resident #11 to the hospital when she asked to go. She would not give her name, so I didn't share any information with her due to HIPAA. I did do an assessment in the morning and continued to do follow up assessments throughout the day. All of my assessments were documented in the computer . Review of resident #11's electronic medical record failed to show documentation of any follow up physical assessments and failed to show documentation of follow up vital signs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request was made on 1/16/25 at 8:17 a.m. for follow up documentation on resident #11's physical assessment from 12/30/24. The facility failed to provide this information prior to the survey exit on 1/16/25. Review of a facility document titled, Documentation of Resident Health Status Needs and Services with a revision date of 10/15/2022, showed, Policy: The resident's medical record is a continuing account of the resident's health status, person-centered plan of care objectives and goal, the treatments/interventions delivered, results of diagnostic tests, and the resident's response to treatment. Procedure: . 2. Document as soon as the resident's encounter is concluded to ensure accurate recall of the data . 4. The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition . 5. Record pertinent resident data that may include but not limited to: a. Change of condition, infection, illness, and ongoing monitoring b. Selected subjective data that validates or clarifies c. Action taken i. Any unusual or abnormal occurrence l. Refusals, noncompliance, behavior occurrences o.document the details of the event, action taken, notifications, monitoring, and follow-ups p. Communication with others regarding the resident. [sic]

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49554 Based on interviews and record reviews, the facility failed to have a registered nurse working at least eight consecutive hours a day, seven days a week. This deficient practice increased the risk to all residents at the facility, in the event RN services were required, but an RN was not scheduled and on shift to provide RN services. Findings include: During an interview on 1/13/25 at 3:39 p.m., resident #10 stated, I think the staff try hard, but I don't think there is enough of them. Sometimes it is hard to be seen by a nurse; they are so busy. During an interview on 1/13/25 at 4:05 p.m., resident #24 stated, The facility has had staffing issues for some time. They have hired quite a few recently. Some of the nurses don't seem like they have control of situations during their shifts. Maybe because they are new. A review of the facility's [NAME] report showed the facility failed to have an RN on shift for the following dates: - 7/13/24; 7/14/24; 7/20/24; 7/21/24; 7/27/24; 7/28/24 A review of actual staffing schedules from July 2024 to October 2024 showed the facility did not have an RN on duty eight consecutive hours per day for the following dates: July: 7/13/24 and 7/20/24 August: 8/9/24, 8/15/24, and 8/29/24 September: 9/26/24 October: 10/3/24, 10/10/24, 10/17/24, and 10/22/24 During an interview on 1/16/25 at 9:45 a.m., staff member B stated, When there isn't an RN scheduled, we find a replacement. We use the Clipboard program to get staff. We also use management staff to cover the floor if we need to. During an interview on 1/16/25 at 9:55 a.m., staff member A stated, We have a corporate person outside of the facility do our PBJ reporting. There should have been an RN on duty daily for at least eight consecutive hours (a day). They have emailed me with concerns about the PBJ reporting.

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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. 48268 Based on observation, interview, and record review, the facility failed to ensure staff practiced appropriate use of personal protective equipment (PPE), during care of residents on enhanced barrier precautions (EBP) on 100 north hall, for 5 (#s 42, 49, 51, 56, and 232) of 30 sampled residents. Findings include: During an observation of the 100 north hall on 1/13/25 at 3:02 p.m., no EBP signs were observed. 1. During an observation on 1/13/25 at 3:40 p.m., resident #56 was observed to have a urinary catheter in place draining clear yellow urine. 2. During an observation on 1/13/25 at 3:55 p.m., resident #51 was observed to have a urinary catheter in place draining clear yellow urine. 3. During an observation on 1/13/25 at 4:12 p.m., resident #42 was observed to have a urinary catheter in place draining clear yellow urine. 4. During an observation on 1/14/25 at 9:15 a.m., resident #49 was observed to have a cholecystostomy tube draining green bile fluid from her right upper abdomen. 5. During an observation and interview on 1/14/25 at 3:24 p.m., resident #232 was observed lying on his side, in bed. An occlusive surgical wound dressing was observed over the resident's left hip. Staff member D stated the dressing was changed in the surgeon's office every three days, and the facility staff were also changing the dressing whenever it became soiled or wet. During an observation on 1/14/25 at 11:40 a.m., staff member I was observed entering resident #232's room and assisted the resident with a transfer from wheelchair to bed. No use of gown or gloves was observed and there was no EBP sign on or near the door. During an observation on 1/15/25 at 7:47 a.m., staff member J was observed in resident #49's room assisting with the resident's personal care needs. No use of gown or gloves was observed. Resident #49 resided in one of the rooms observed to not have an EBP sign on the door alerting staff of necessary PPE precautions. During an observation on 1/15/25 at 9:33 a.m., staff members I and G were observed in resident #56's room, providing personal care. No gowns were worn at any time during the observation. Resident #56 resided in one of the rooms observed to have no EBP sign on the door. During an observation of the 100 north hall on 1/15/25 at 4:02 p.m., there continued to be no EBP signage posted in any area. During an interview on 1/14/25 at 11:20 a.m., staff member I stated there were currently no residents who required the use of PPE in the 100 north hall as there were no signs to designate the need for PPE. Staff member I stated the CNA staff do not usually share information on EBP statuses in their shift report, as there would be signs on the doors to tell them who required PPE for cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with staff members C and D on 1/15/25 at 12:40 p.m., staff member D stated EBP would be required for any resident, .with a catheter, wound, colostomy, or basically any other tube or drain coming from their body. Staff member C then asked, What is EBP? During an interview on 1/15/25 at 10:22 a.m., resident #49 reported staff wore gloves when changing her dressing or emptying her drain, but gowns were not worn. During an observation and interview on 1/15/25 at 1:40 p.m., staff member E stated there were several residents on the 100 north hall currently on EBP. Staff member E stated, There should be signs on the doors for every resident with EBP. This surveyor and staff member E toured the 100 north hall together, at the time of the interview, and observed no EBP signage. Review of a facility document, titled, Transmission-Based Precautions Conventional Plan, last revised on 4/2/24, showed the following: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact activities. High contact activities may include: a. Dressing b. Bathing/Showering c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. h. Wound care; any skin opening requiring a dressing. [sic]

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 48268 Based on interview and record review, the facility failed to maintain the antibiotic stewardship program to include infection surveillance and monitoring of antibiotic use. This deficient practice increased the risk of a negative outcome for all residents receiving prescribed antibiotics who were at an elevated risk for multi drug-resistant infections. Findings include: During an interview on 1/15/25 at 1:40 p.m., staff member E stated she had been in her role since November 2024. Staff member E stated, I am trying, but I don't have a lot of support, so I just do what I can. Staff member E reported some of the healthcare providers prescribing antibiotics within the facility do not follow McGreer's criteria and sometimes treat with antibiotics based on behavior or symptoms, and added, . but I can't tell the doctors what to do. During a combined interview and record review on 1/15/25 at 2:45 p.m., the facility's infection control log was reviewed and discussed with staff member E for the period of December 1, 2024 through December 31, 2024. The log showed a total of 20 infections for the month, which included wound, skin, lung, fungal, and urinary infections. Seven of the 20 identified infections were listed as urinary tract infections. One urinary tract infection showed a urine culture and sensitivity was obtained and the organism was identified on the log. The remaining six urinary tract infections showed no urine culture and sensitivity was obtained, and showed the residents listed were prescribed antibiotics. Of the 20 infections listed on the log for the month, two organisms were identified in total. Three infections showed hospital under the column titled, culture. Staff member E stated when they come from the hospital on antibiotics, she does not track the organisms, stating it was difficult to obtain results from the hospital lab. Review of a facility document titled, Antibiotic Stewardship, last revision date of 10/15/22, showed the following: . The Infection Preventionist utilizes microbiologic, clinical symptoms and radiologic findings to confirm evidence of infection.v alidates the infection meets the definition of an active infection utilizing McGreer's Criteria. The Infection Preventionist/designee(s) . Reviews culture and sensitivity reports routinely as part of the surveillance of the infection.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 48268 Based on interview and record review, the facility failed to ensure residents were screened for influenza, pneumonia, and COVID-19 immunizations; and failed to offer or obtain a signed declination for pneumococcal vaccines, for 3 (#s 28, 45 and 232) of 5 residents sampled for immunizations. Findings include: 1. Review of resident #28's vaccination history, not dated, failed to show the resident received an updated pneumococcal vaccine per CDC guidelines, and failed to show a signed declination for the vaccine. His last pneumococcal vaccine (PCV13) was administered in 2000 (year). 2. Review of resident #45's vaccination history, not dated, failed to show administration or a signed declination for pneumococcal vaccine (PCV13, PCV15, PCV21 or PCV23). 3. Review of resident #232's vaccination history, not dated, failed to show administration or a signed declination for pneumococcal vaccine (PCV13, PCV15, PCV21 or PCV23). During an interview on 1/15/25 at 1:45 p.m., staff member E stated she had only been in her role since November 2024. Staff member E stated she did not know she was responsible for immunizations as part of her position. Staff member E stated she ordered the pneumococcal vaccines from the pharmacy on 1/15/25, in response to the surveyor's request for vaccination documentation. Review of a facility policy titled, Pneumococcal Program, revised on 11/22/24, showed the following: .To reduce the risk of pneumococcal infection and transmission, residents and family members receive education regarding the benefits of pneumococcal immunization. Residents are offered and given the pneumococcal vaccine in accordance with physicians' orders unless: a. Medically contraindicated, b. The resident has already received the immunization or c. The resident or resident advocate refuses. [sic]