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	02/26/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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.

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to ensure staff utilized personal protective equipment properly during care of residents who were positive with COVID-19, and for a resident who was on droplet precautions, for 3 (#s 7, 10, and 32) of 18 sampled and supplemental residents; and failed to maintain a system of communicable disease surveillance for tracking of active infections in the facility. The deficient practices placed residents, staff, and visitors at risk for the transmission of infections. Findings include:1. During an observation and interview on 2/24/26 at 9:52 a.m., staff member AA and staff member BB were inside resident #10's room, with the door open. The outside of the door had signage showing enhanced droplet precautions were in place for resident #10. The two staff members had respirators on but were not wearing an isolation gown, disposable gloves, or protective goggles. Staff member BB proceeded to reposition resident #10 in his bed, directly touching him with her own ungloved hands and clothing. Resident #10 was heard coughing several times while the two staff members were repositioning the resident. Staff member AA exited the room and stated she was shadowing staff member BB. Staff member BB stated they knew resident #10 was COVID-19 positive and saw the infection control precaution sign on his door. Staff member BB stated, I knew he was COVID positive, that's why we were wearing masks, I didn't think to put on a (isolation) gown and gloves. Staff member BB stated she usually looked at a resident's door to see what kind of infection control precautions to follow before entering the resident's room. During an interview on 2/26/26 at 10:12 a.m., staff member B stated she started in her position in mid-January (2026). Staff member B stated that the previous director of nursing covered the infection preventionist role. Staff member B stated there were areas of the infection control program that needed to be caught up on. Staff member B stated she was working on updating the infection surveillance logs. Staff member B stated she heard of staff in the facility, during the week of the survey, who did not wear personal protective equipment (PPE) when entering resident rooms when the resident was COVID-19 positive. Staff member B stated that all staff members in the facility, including hospice nurses, needed to wear the proper PPE for residents with droplet precautions. Review of resident #10's nursing progress notes, dated 2/21/26 at 3:28 p.m., showed: Note Text: Resident tested for COVID due to facility outbreak status. Resident tested positive today. Resident reports he's having body aches and increased fatigue. Resident's spouse. notified. PPE put in place. Review of resident #10's physician orders, dated 2/21/26 at 1:50 p.m., showed: Enhanced Droplet Precautions with contingency use PPE (Gown, N95 mask, eye protection, and gloves) for Dx of COVID-19. May re-eval after 10 days from symptoms onset/positive test, no fever for past 24-hours without the use of fever-reducing medication, and improvement of symptoms. every shift for covid for 14 Days. [sic] 2. During an observation and interview on 2/23/26 at 3:58 p.m., resident #32 was sitting in a wheelchair in his room. Resident #32 was heard exhibiting a frequent mucous-sounding cough. Two CNAs were observed going into resident #32's room. Resident #32's door had an infection control precaution sign posted on it showing that droplet precautions were to be used. The directions instructed the staff to wear eye, nose, and mouth coverings before entering the room. A second sign showed enhanced droplet precautions. This sign instructed the staff to wear full personal protective (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	equipment (PPE). This included gowns, eye protection, N95 masks, and gloves. The sign also directed the staff to remove the gown and gloves and complete hand hygiene. When this surveyor heard resident #32 holler out, Ow! it was noted that the two CNAs were starting to transfer resident #32 back to bed. The two CNAs had masks and gloves on, but neither staff member was wearing eye protection or an isolation gown. After completing the resident's care, staff member V left resident #32's room without washing or sanitizing her hands. Staff member V said she removed her gloves and did not wash her hands, and she would use the hand sanitizer down the hallway from resident #32's room. Review of resident #32's lab report, dated 2/17/26, showed that resident #32 tested positive for Parainfluenza Virus 2. 3. On 2/24/26 at 9:13 a.m., the surveyor was in resident #7's room, and the resident was COVID-19 positive. A garbage can was observed across the resident's room, in the bathroom. As the surveyor was leaving the room, it was noted that there was no bin available for the soiled personal protective equipment. During an observation and interview on 2/24/26 at 9:16 a.m., staff member R brought two pairs of goggles to the isolation cart outside resident #7's room. Staff member R said there should be sanitizing wipes to clean the goggles off, but none were available at that time. Staff member R said she had to take her isolation gown off in the resident's bathroom and walk back through the resident room. Staff member R said she should not have done that, but there was no bin by the resident's door to place the used isolation supplies in. Staff member R said she told the nurse about the concern with the lack of a garbage bin by the resident's door. Staff member U said there should have been a garbage bag set inside the resident's door, so isolation gowns could be removed. Staff member U said the garbage bin should be in place for the disposal of used personal protective equipment. During an observation and interview on 2/26/26 at 11:20 a.m., staff member S was observed coming out of resident #7's room, and the resident was COVID-19 positive. Staff member S was all the way into the hallway with her gown, gloves, mask, and goggles on. Staff member S placed resident #7's food tray into a plastic bag. Staff member S then tied the plastic bag shut with her contaminated gloved hands. Staff member S then took off her isolation gown, removed her goggles and mask, and then removed her gloves without washing her hands. Staff member S used her contaminated hand to toss her hair, which was in a ponytail, over her head. She then went to the housekeeping cart and touched the surface of the cart and the supplies on the cart. Staff member S then went to the plastic bag on the floor near resident #7's room, which was full of garbage. She tied the bag closed. Staff member S said she had received training on COVID-19 and housekeeping practices. Review of a facility document titled Infection Control Log, dated January 2026, showed a list of 20 residents, including the names of the antibiotics they were taking. There was no tracking information on the log to show the resident's room number, admit date , onset date, site, infection-related diagnosis, healthcare-acquired infection status, or resolution date. The total number of infections was blank at the bottom of the log, and there was no information documented in any of the infection categories to show the number of the types of infection, such as skin, eye, upper respiratory, and or others. The January 2026 log had two pages of facility maps, with no tracking information for the infection types or the resident rooms identified for those who had active infections. Review of a facility policy titled Infection Control Surveillance Plan, revised 9/22/25, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	. 3. Areas that facilities could consider for process surveillance include the following but are not limited to:. b. Appropriate use of personal protective equipment (PPE). h. Appropriate use of transmission-based precautions. 6. The Infection Preventionist (IP). reviews data by tracking and trending signs and symptoms of infection, as well as acute infections, to identify potential clusters and emerging trends. Review of a facility policy titled, Management of COVID-19, . revised 9/18/25, showed: .This facility is committed to protecting the health and safety of residents, staff, and visitors through proactive COVID-19 prevention and response measures.1. The facility should follow the Core Principles of COVID-19 Infection Prevention and Control:a. Hand hygiene (use of alcohol-based hand rub is preferred) practices .b. Face covering or masks (covering mouth and nose) . e. Appropriate staff use of Personal Protective Equipment (PPE). 6. Residents should be monitored for signs and symptoms of COVID-19. If noted, the facility should promptly place the resident on Special Droplet and Contract Precautions (formally referred to as Enhanced Droplet Precautions) . [sic]

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to maintain an infection surveillance and antibiotic stewardship program to ensure tracking of effective and efficient antibiotic therapies for residents residing in the facility. Findings include:During an interview on 2/26/26 at 10:12 a.m., staff member B stated she started in her position in mid-January (2026). Staff member B stated the previous director of nursing covered the infection preventionist role. Staff member B stated there were a lot of infection control areas of the program that needed to be caught up on. Staff member B stated she was working on the infection surveillance and antibiotic stewardship logs.Review of a facility document titled, Infection Control Log, dated January 2026, showed a list of 20 residents, with the names of the antibiotics they were taking. There was no tracking information on the log to show the associated room number, admit date , onset date, site, infection-related diagnosis, culture, organism, isolates, healthcare acquired infection status, date of re-culture, or resolution date. The total number of infections was blank at the bottom of the log, and there was no number in any of the categories of infections, to show the number of infections such as skin, eye, upper respiratory and others.Review of a facility policy titled, Antibiotic Stewardship Program, revised 8/10/25, showed: . f. Assess the response to antibiotic therapy, resident condition and review laboratory results as they become available to determine whether the current antibiotic remains appropriate or requires modification. 4. Tracking. b. Contain a system of reports related to monitoring antibiotic usage and resistance data. Examples may include the following:I. Summarizing antibiotic use from pharmacy data or electronic health records, such as the rate of new starts, types of antibiotics prescribed, or days of antibiotic treatment per 1,000 resident days.

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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. Based on observation and interview, the facility staff failed to ensure a resident was assisted with maintaining a dignified existence when the staff did not identify and provide personal care to a female resident who had dark facial hair that she wanted shaved off, and the facial hair bothered the resident, for 1 (#71) of 15 sampled residents. Findings include:During an observation and interview on 2/24/26 at 8:37 a.m., resident #71 was sitting at the breakfast table. Resident #71 was observed to have lots of dark chin and upper lip hair. Resident #71 said she wished the staff would shave her facial hair because it bothered her.During an observation and interview on 2/25/26 at 3:30 p.m., resident #71 was lying in bed. Resident #71 was observed to be pulling at her chin hairs. Residents #71's facial hair was unchanged from 2/24/26. Resident #71 said she would like to be shaved.During an interview on 2/25/26 at 3:33 p.m., staff member M said she takes care of resident #71. Staff member M said she gives resident #71 a bath on Mondays and shaves her facial hair during the bath. Staff member M said she was not here this Monday, and she did not know if resident #71 had been shaved.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure an investigation of a facility reported incident was completed with thorough documentation of the findings for 1 (#70) of 15 sampled residents. Findings include:Review of a Facility Reported Incident, dated 1/26/26, showed resident #70 was in a dining room and observed by staff to physically interact with a female resident, which included kissing her. The findings, submitted 2/2/26, showed female residents on the wing had been interviewed, and the female resident in the incident had been moved from the wing.During an interview on 2/26/26 at 10:22 a.m., staff member B stated resident #70's care plan should have been updated to include monitoring for recent changes in behavior after a physical incident with another resident. Staff member B stated the incident that occurred towards the end of January (2026) must have happened when she and staff member A were not in the facility, but out of town. Staff member B stated staff member A handled facility reported incidents. Staff member B stated if a resident-to-resident incident occurred, there was usually monitoring or alert charting started for both residents.Review of the event documentation showed the facility did not complete a thorough investigation, including interviews with other staff members, monitoring for awareness of details or ongoing patterns of behavior for those residents involved, a review or update to resident #70's care plan, and there were no interdisciplinary team event notes regarding the incident.Review of a facility policy titled, Event Management & Reporting, revised 9/16/25, showed: . 4. Investigation and Intervention. c. The Interdisciplinary Team (IDT) will conduct a thorough review to confirm or revise the initial findings.d. Based on the initial investigation, the nurse will implement an immediate intervention and update the resident's care plan. f. The IDT will determine whether the initial intervention is sufficient or requires adjustment. Any changes will be documented in the care plan.5. Resolution and Oversight. a. The Director of Nursing and/or Nursing Home Administrator is responsible for final resolution (locking) the event in the EMR.b. Sign-off by the Nursing Home Administrator confirms the investigation is complete and reviewed for abuse or neglect. If substantiated, the event will be reported to all required parties.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 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]

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to ensure a baseline care plan was developed within 48 hours after a resident's admission, to reflect monitoring of high-risk medications used by the resident, for 1 (#79) of 15 sampled residents. Findings include:During an interview on 2/24/26 at 10:04 a.m., resident #79 stated she had just gotten to the facility and already wanted to go home. Resident #79 stated she wanted to speak with the staff about going home.Review of resident #79's February 2026 medication administration record showed an admission date of 2/20/26, and included physician orders for: - . Insulin Glargine Subcutaneous Solution 100 UNIT/ML. Inject 15 unit subcutaneously in the morning for DM (Diabetes Mellitus) ., - . Apixaban Oral Tablet 5 MG. Give 2 tablet by mouth two times a day for anticoagulant for 5 Days -Start Date- 02/20/2026.,- . Apixaban Oral Tablet 5 MG. Give 1 tablet by mouth two times a day for anticoagulant for 85 Days -Start Date- 02/25/2026. [sic]Review of resident #79's baseline care plan, initiated 2/20/26, showed pertinent diagnoses of Type 2 Diabetes Mellitus, other Pulmonary Embolism with acute Cor Pulmonale, and other symptoms and signs involving cognitive functions following Cerebral Infarction. It showed the focus area in the plan of care: Impaired mobility with risk for falls r/t, with no goals, and an intervention, PHARMACY: Pharmacist review of medications to address fall risk side effects. Develop plan with risks and benefits as indicated. [sic] Resident #79's baseline care plan did not include information about the prescribed high-risk medications of insulin and an anticoagulant, to include monitoring for signs and symptoms related to hypoglycemia with interventions, and monitoring for signs and symptoms associated with administration of an anticoagulant.Review of a facility policy titled Baseline Care Plans, revised 9/3/25, showed: . 1. A baseline plan of care is developed within 48 hours of admission to address the immediate needs of the residents and will be utilized/updated as needed until a comprehensive care plan can is developed and implemented.2. The baseline care plan should include the minimum healthcare information necessary to properly care for the resident upon their admission which includes the following, at a minimum:a. Initial goals based on admission orders and desired outcomesb. Physician orders .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to implement a care plan for individualized shower preferences to maintain resident cleanliness and ensure the resident felt their hygiene needs were met, for 1 (#42) of 15 sampled residents. Findings include:During an observation and interview on 2/24/26 at 8:55 a.m., resident #42 was sitting in her recliner. The resident's hair was braided and appeared disheveled with strands of hair hanging on both sides of her face. Resident #42 stated she was upset because she had not received a shower two times a week on Tuesday and Friday. She stated she needed assistance while showering, and the facility staff were too busy to get showers done. Resident #42 stated she did not feel clean when she did not receive her shower two times a week.During an interview on 2/26/26 at 8:35 a.m., staff member N stated the MDS nurse completes resident care plans. Staff member N stated, I think she does all the care plans.During an interview on 2/26/26 at 9:15 a.m., staff member E stated she was not certain who is responsible to complete a resident's plan of care, as it was already in the resident's electronic medical record. Staff member E stated she does not update care plans.During an interview on 2/26/26 at 9:30 a.m., staff member G stated that care plans are completed by the nurse managers. Staff member G stated she had not completed a resident care plan.Review of resident #42's care plan dated 1/21/26 showed the focus area as the resident had an ADL self-care deficit. The resident's care plan goal was to improve her current level of functioning in bathing. Resident #42's care plan did not have interventions related to the resident's bathing preferences of two times a week, or what bathing services were necessary, such as the frequency, to ensure the resident's hygiene needs were met. Review of a facility document titled Comprehensive Care Plans and Conferences, with a revision date of 9/3/25, showed: . The facility will ensure that each resident has a timely, person-centered comprehensive care plan developed and maintained in accordance with professional standards of practice. The care plan will reflect the residents' individual conditions, risks, needs, behaviors, cultural values, and preferences, and will include measurable goals, appropriate interventions, and realistic timeframes. The plan will be created, reviewed, and revised by an interdisciplinary team familiar with the residents' status and care needs, with active involvement from the residents and their representative, when applicable. Updates to the care plan will occur as needed based on the residents' response to interventions or changes in condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update a resident care plan based on an individual resident's care needs related to behaviors exhibited, for 1 (#70) of 15 sampled residents. This deficient practice placed resident #70 at risk for unmet needs and or the lack of behavior monitoring to identify changes. Findings include:Review of resident #70's nursing progress notes, dated 1/26/26 at 3:48 p.m., showed: Note Text : CNA alerted this nurse to an occurrence in which rsdt walked behind another female rsdt who was sitting at the dining room table. Rsdt was witnessed rubbing female's shoulders and arms from behind, then bending over and giving the rsdt a kiss on the cheek. Female rsdt not of sufficient cognition to grant consent. Rsdt and female separated, but both still in the common area under supervision. DON and Administrator notified. [sic]During an interview on 2/26/26 at 10:20 a.m., staff member B stated resident #70's care plan should have been updated to include monitoring for recent changes in behavior after a physical incident with another resident. Staff member B stated the incident that occurred towards the end of January (2026) must have happened when she and staff member A were not in the facility, but out of town.Review of resident #70's comprehensive care plan, initiated 9/11/25, showed resident #70 had a diagnosis of unspecified Dementia, unspecified severity, with other behavioral disturbance. A problem included, [Resident #70] uses anti-psychotic medications r/t PTSD, antisocial personality disorder., with a goal of [Resident #70] will have behaviors managed for quality of life. Resident #70's comprehensive care plan did not include information about updated monitoring of physical behaviors towards other residents following the 1/26/26 incident in the dining room.Review of a facility policy titled Comprehensive Care Plans and Conferences, revised 9/3/25, showed: . The facility will ensure that each resident has a timely, person-centered comprehensive care plan developed and maintained. The care plan will reflect the residents' individual conditions, risks, needs, behaviors. and will include measurable goals, appropriate interventions, and realistic timeframes. Updates to the care plan will occur as needed based on the residents' response to interventions or changes in condition.

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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 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: POLICYResidents 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:I. Hygiene: Bathing, dressing, grooming, oral care .4. Documentation and ReportingI. ADL assistance and resident response are documented in the medical record .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide necessary care and services to promote the highest practicable well-being for range of motion for 1 (#71) of 15 sampled residents. The resident's range of motion limitations affected her ability to complete or participate in ADL care and increased the risk of continued deterioration in range of motion. Findings include: During an observation and interview on 2/24/26 at 8:37 a.m., resident #71 was observed seated in a wheelchair with her left elbow, wrist, and fingers in a flexed position. When resident #71 was asked if she received help with exercising her arm, she stated, No. Resident #71 said her wrist and her hand were numb. Resident #71, using her right hand, moved the hand and wrist, but she could not move them to a straight position. Resident #71 said she would do exercises if they were provided by the facility.Review of resident #71's Minimum Data Set (MDS), with an Assessment Reference Date of 2/21/25, showed under Section GG - Resident #71 had an upper extremity, shoulder, elbow, wrist, and hand impairment on one side of her body.Review of resident #71's comprehensive care plan, last reviewed on 11/10/25, did not show that the facility identified the resident's left-hand range of motion limitations, and the care plan did not include interventions to address the range of motion limitations for the resident, positioning, or a therapy evaluation.A request was made to the facility for a contracture assessment and restorative plan for resident #71. The facility provided an undated form that showed resident #71 did not have an assessment for contractures, and there was no plan of treatment identified or restorative services. Resident #71 was not receiving therapy for her arm, elbow, wrist, or hand.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to review the risks and benefits of using a mobility bar and failed to obtain safety measurements for mobility bars attached to the bed, for 2 (#s 1 and 71) and failed to obtain informed consent prior to the installation of the mobility bar for 1 (#71) of 15 sampled residents. The failure placed the residents at risk for entrapment. Findings include:During an observation and interview on 2/24/26 at 9:34 a.m., resident #1 said she did use the mobility bar on the side of her bed to steady herself. Resident #1 said she fell out of bed on Sunday (2/22/26) as she got between the head of the bed and the mobility bar. The mobility bar was observed to be in a stationary upright position about 1/3 of the way down the side of the bed.F700 - Side Rails, of the Appendix PP, State Operations Manual, showed, . Examples of bed rails include, but are not limited to: Side rails, bed side rails, and safety rails; and Grab bars and assist bars. 1. Review of resident #1's Post Fall Evaluation, dated 2/23/26 at 6:00 a.m., showed the investigation did not include the assessment of the mobility bar used for resident #1, and it was not assessed for the risk it posed for future falls. During an observation and interview on 2/24/26 at 12:20 p.m., staff member F measured the mattress, the bed, and the mobility bar. When the mattress was pushed until it stopped, there was a nine-inch gap from the mattress to the mobility bar. The measurement from the head of the bed to the mobility bar showed a 24-inch gap. When staff member F was asked about measuring the zones for the FDA (Food and Drug Administration) he said he did not know what that was, and he had never been asked to measure the mobility bars because they were just mobility bars, and not real side rails. The facility policy titled, Bed Rails, showed the facility will evaluate the resident's risk for use, safety, and the risk for entrapment prior to a bed rail being used. The facility failed to follow its policy when resident #1 was not assessed for entrapment between the mobility bar and the mattress. The facility could not show what alternative was attempted before the initiation of the mobility bar. No education and risk versus benefit assessment was completed, establishing that the resident was aware of the risks of using a mobility bar. The consent showed the risks versus benefits were not signed until 2/26/26. Review of resident #71's Acknowledgment of Assistive/Enabling Device Use, for the mobility bar, dated 2/26/26, showed that a documented benefit was to prevent falls out of bed. The medical symptoms being treated were weakness, fall risk, and impulsiveness. During an observation and interview on 2/25/26 at 3:30 p.m., three surveyors observed resident #71's mobility bar. The mattress was not stable, and when moved, the gap between the mattress and the mobility bar was more than six inches. The gap between the head of the bed and the mobility bar was approximately twelve inches. Resident #71 said she used the mobility bar to help move herself when needed. 2. Review of resident #71's Bed Safety and Transfer Device Evaluation, dated 2/16/26, showed that a bed mobility bar was used, and resident #71 needed extensive assistance for bed mobility. The assessment showed that resident #71 was confused, weak, and had hemiplegia. The assessment showed the mobility bar was used to improve bed mobility and reduce the risk of falling out of bed. The assessment showed the bar was installed per the manufacturer's recommendations, and the bed system met the FDA bed safety recommendations, with gaps less than 4 inches, to prevent entrapment. During an interview on 2/26/26 at 10:23 a.m., staff member B said it was her understanding that the assistive bars and mobility bars had evaluations completed for the use of them. Staff member B said the therapy department completed the evaluations on the beds. Staff member B said the beds were built a certain way, and there were only certain ways to put the mobility bars on the beds. Staff member B said she was unaware whether measurements of the beds and mobility bars were completed.Review of the facility's policy titled, Bed Rails Safe and Effective Use of Bed Rails, with a revision date of 4/28/25, showed:1. Residents who require the use and/or request the use of bed rails will be evaluated prior to the initiation of bed rails. Evaluation to include (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but not limited to: residents' indication for use and resident's risk for entrapment.2. Facility associate will offer other assistive alternatives prior to the initiation of the bed rails.3. If a bed rail is utilized, the risks and benefits of bed rail usage will be reviewed with the Resident and/or Resident representative, and Resident's consent will be obtained prior to installation of the bed rails or as soon as possible.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label a medication with an open date and failed to dispose of an expired vaccine. This deficient practice had the potential to affect any resident using the identified medications/supplies. Findings include:During an observation on [DATE] at 10:08 a.m., the Floor 2 nursing medication storage room contained the following open and expired medical supplies:- 1 vial Tuberculin solution opened, not dated.- 1 syringe Adacel Tdap vaccine, expiration date [DATE].During an interview on [DATE] at 10:28 a.m., staff member G stated it was the expectation of all nursing staff to check for outdated supplies, but this was the primary responsibility of the night shift nurse. Staff member G stated the Pharmacist also inspected the medication carts and medication storage rooms once a month and removed expired items. Staff member G stated it was the responsibility of the nurse who opened a new stock of a product to write an open date on the bottle/product. She stated she was not sure why the tuberculin solution did not have an open date on the bottle.Review of a facility document titled, Pharmacy Services, with a revision date of [DATE], showed: Policy. This policy outlines the responsibilities of the pharmacy and facility in coordinating pharmaceutical services that supports resident care and regulatory compliance.Procedure. 3. The pharmacist, in collaboration with the facility and medical director, helps develop and evaluate the implementation of pharmaceutical services procedures that address the needs of the residents, are consistent with state and federal requirements, and reflect current standards of practice. These procedures address, but are not limited to:. e. Disposing;f. Labeling and storage of medications; .[sic]

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure documentation for the education, and the signed consent or declination of the influenza or pneumococcal immunizations by the resident or their responsible party, for 1 (#5) of 5 residents sampled for vaccinations. Findings include:During an interview on 2/26/26 at 10:02 a.m., staff member B stated some residents were behind on their immunizations, to include documentation in their medical record. Staff member B stated she was starting to work on updating immunizations. Staff member B stated she started in the director of nursing and infection preventionist roles in mid-January (2026). Staff member B stated resident #5 should have been offered immunizations when she was admitted in December (2025). Staff member B stated residents new to the facility were offered flu and COVID immunizations, and staff would check the resident's imMTrax (State immunization record system).A request was made on 2/25/26 at 10:50 a.m. for resident #5's consent and declination forms including education for COVID-19, pneumococcal, and influenza vaccines. The facility provided a document which stated, There is no declination form uploaded for [Resident #5].Review of a facility policy titled, Influenza Outbreak Management, revised 9/10/25, showed: . The facility will actively monitor residents. for signs of influenza and will promptly screen. and implement measures to prevent its spread. 1. Offer influenza vaccines annually to all residents. in long-term care settings to help reduce transmission of influenza. and influenza-related illness and death.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure documentation was completed and maintained to show education was provided to the resident or their representative related to the risks and benefits of the COVID-19 vaccination, for 1 (#5) of 5 sampled residents for vaccinations. Findings include:During an interview on 2/26/26 at 10:02 a.m., staff member B stated it had been identified that some residents were behind on their immunizations, and that included documentation in the medical records. Staff member B stated it was an area of the infection control program she was starting to work on. Staff member B stated that newly admitted residents were offered flu and COVID immunizations, and the residents' imMTrax (State immunization record system) was checked. Staff member B stated that resident #5 should have been offered immunizations when she was admitted in December (2025).Review of resident #5's comprehensive care plan showed an admission date of 12/9/25. The care plan included a problem, initiated 2/23/26, of . enhanced droplet precautions r/t positive COVID-19 diagnosis.A request was made on 2/25/26 at 10:50 a.m., for resident #5's consent and declination forms, including education for COVID-19, pneumococcal, and influenza vaccines. The facility provided a document which showed, There is no declination form uploaded for [Resident #5].Review of a facility policy titled, COVID Vaccination for Residents, revised 9/25/25, showed: . 1. Offer and Educatea. Each resident should be offered COVID immunization, unless the immunization is medically contraindicated, or the resident has already been immunized. Prior to offering the vaccine, each resident or representative should receive education regarding the benefits and potential side effects of the immunization. 4. Immunization and Documentation. e. If the resident has previously received the vaccine, the facility should request vaccination documentation to confirm vaccination status.f. Refusals should be documented in the medical record .