STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observations, interviews, and record review, the facility failed to remove expired items for disposal for one medication room, one central supply room, storage closet, and three medication carts; keeping items off the floor in one medication room, one supply room and a storage closet; store supplies in a clean environment, free from debris falling on supplies for one central supply room; and failed to ensure a schedule II controlled substance, morphine, was locked up from other residents and staff preventing the risk of tampering for 1 (#59) of 27 sampled residents. These failures increased the risk of expired items being used, when stored unsafely, for resident care, if taken from the identified medication rooms and carts. This deficient practice also placed wandering residents at risk of narcotic ingestion, potential diversion, and decreased pain management for resident #59. Findings include: 1. During an observation and interview on [DATE] at 3:08 p.m., resident #59 had an IV bag of morphine (10mg/mL concentration) hanging on a command strip at the top of her bed. This medication was not locked up but was running through a CADD pump into resident #59's PICC line (peripherally inserted central catheter). There were command stickers on the bottom of the CADD pump but the stickers no longer held the CADD pump to the ledge near resident #59's head of her bed, and it was easy to remove. Resident #59 stated the CADD pump had been in her room for a few weeks and hospice managed the pump. During an interview on [DATE] at 10:05 a.m., staff member J stated all narcotics were double locked up in the medication cart. Staff member J stated there was potential for a staff member or another resident to steal or divert the morphine medication as it was not locked up. During an interview on [DATE] at 10:42 a.m., NF2 stated there was not usually a lock around the morphine medication, but there was a code on the CADD pump which prevented tampering of the medication. During an interview on [DATE] at 11:00 a.m., NF3 stated the CADD pump had a lock which prevented anyone except those with the code to change the settings. NF3 stated the tubing was locked in the cassette but the medication itself was not locked up. NF3 stated, It is the standard to lock up medications. NF3 stated once medications were dispensed to the resident, it was hard to keep it locked up and gave an example of a fentanyl patch. NF3 stated, I would probably have a system to monitor that (resident #59's morphine) at the facility, but stated they were unsure of how the facility should do that. NF3 stated there was a potential someone could divert or steal the medication as it was not locked up. During an observation on [DATE] at 11:33 a.m., resident #59's CADD pump showed 10 medication administrations given, and 10 attempts. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and observation on [DATE] at 11:47 a.m., staff member R had clicked many of the CADD pump buttons including the dose button. The machine then beeped, and the CADD pump now showed 11 medication administrations given and 11 attempts. Staff member R stated the CADD pump for resident #59 did not seem to be fully locked as she was able to give a dose of the medication instead of just the resident giving the doses to herself. Staff member R stated resident or self-administration was the intention of the CADD pump. Resident #59 stated she had not pushed the medication administration button since the surveyor had last been in the room with her at 11:33 a.m. During an interview on [DATE] at 8:47 a.m., staff member D stated I don't know why we never locked it up. This is our first CADD pump that we've had here. Review of a facility document from [Entity Name] Hospice, titled Medication – CADD PCA Pump, dated [DATE], showed: . 4. Pump Setup and Programming . g. Lock keypad and cassette to prevent tampering; use tamper-proof features if risk of misuse. 2. During an observation and interview on [DATE] at 11:30 a.m., with staff member B, the following items were found: On a medication cart: - Saline nasal spray expired on 1/26 and one expired on 10/25, In the medication supply room: - A sharps container with a used needle in it which had no lid, - Calcium 600 mg expired 8/25, - Probiotic Acidophilus expired 2/25, - Milk of Magnesium expired 5/25, - Tums 500 mg expired 12/25, - Vitamin C 500 mg expired 12/25, - Geri-Kot expired 5/25, - Omeprazole 20 mg expired 4/25, - 1 box of grey sodium fluoride 5 mg lab draw tubes expired [DATE], - 35 Vacuette pink top blood draw tubes expired [DATE], - 43 Vacuette blue top blood draw tubes expired [DATE], - one bottle aspirin 325 mg expired 8/25 and one expired 6/25, and - one bottle gas relief expired 5/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The floor was dirty and had not been mopped. Staff member B stated there had been difficulty coordinating time for housekeeping to clean the medication room with a nurse present. The was an area approximately 12 inches x 4 inches of missing tile. In the Central Supply room: - one case of lotion stored on the floor, - six cases of briefs on the floor, - four 10 cc flushes expired 11/24, - 25 xeroform dressings expired, - 19 Tegaderm pads expired, - three bottles of adult liquid acetaminophen 500mg/15mL expired 7/25, - a case of bed pans, two cases of urinals, and two cases of briefs stored on the floor, - 14 Insyte auto guard 18-gauge x 1.16 in expired, - two Clearlink system with regulator expired 9/12, - Infusion set expired 5/20, - four Polymem Silver 4.25 x 12.5 in expired 9/23, - 32 Dairy aid expired 1/26, - 14 bottles of Brava powder expired [DATE], - 15 bottles of Brava powder expired [DATE], and - one bottle of Magnesium Chloride (slow Mag) expired 11/25, In the respiratory cart: - one bottle of Bisacodyl 5 mg expired 9/24, - one bottle of Thamin expired 1/25, - one bottle of vitamin D expired 10/25, - one bottle of Melatonin 3 mg expired 1/25, - one bottle of Zinc 50 mg expired 3/25, - one bottle of folic acid 800 mcg expired 10/24, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- one bottle of omeprazole expired 4/25, - one bottle of allergy 10 mg expired 11/25, - one wound gel Revyve expired 9/25, - one lyophilized antigen component (RSV) expired [DATE], In the wound cart: - Calcium alginate open and half used, - one non-adhesive pad opened and partially used, - one Urgoclean Ag opened, and three-quarter used, - one Puracol open and half used, - one Optiview Hydro core Sterile Dressing open and half used, and - one Tegaderm film 6 x 8 in expired [DATE]. The wall behind the catheter supplies showed old moisture damage and the top of the wall had exposed dry rotten wood causing wood debris to fall on the sterile supplies. The floors had debris and was dirty. In the closet outside the central supply labeled oxygen: - three cases of oxygen tube bags stored on the floor, - three cases of external nasal tubing on the floor, - one case of nasal masks on the floor, - two cases of non-rebreather masks on the floor, and - and one case of humidifier bottles on the floor. Review of the facility's policy, Medication storage, dated [DATE], reflected, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure the food temperature was served at a palatable temperature for 5 (#s 20, 24, 36, 58 and 59) of 27 sampled residents. This deficient practice resulted in residents reporting disliking the food and resulted in residents eating less. Findings include:During an interview on 2/7/26 at 3:08 p.m., resident #59 stated the food was cold when it arrived to her room.During an observation and interview on 2/8/26 at 7:57 a.m., staff member S measured the temperatures from the steam table. The bread puree was at 133 degrees Fahrenheit. Staff member S stated the bread puree was supposed to be between 145 and 170 degrees Fahrenheit.During an observation and interview on 2/8/26 at 8:05 a.m., staff member S took the temperature of resident #36's food after it had been delivered to her room. The temperature of the yogurt was 61 degrees Fahrenheit, the waffle was 107 degrees Fahrenheit, the sausage was 109 degrees Fahrenheit, and the sugar free crystal lite was 55 degrees Fahrenheit. Staff member S stated the cold items on resident #36's plate should have been 40 degrees Fahrenheit or below. Staff member S stated they felt the food was cold in the resident's rooms because staff members often left the food cart door open, there was no bottom warmer located on the plate of resident #36's food, there was no source of heat in the cart, and there were so many residents that ate in their room that all of the trays could not fit in the food cart. Staff member S stated sometimes there was a different cart used to deliver food that was not insulated. Staff member S stated those resident's food could be cold as well.During an interview on 2/8/26 at 8:13 a.m., resident #36 stuck her finger in her waffle and stated the waffle was cold. She stated the strawberry sauce on top of the waffle made it soggy so she would not eat it even if it was hot. She stated the sausage felt lukewarm and the tropical punch juice was semi cold.During an interview on 2/9/26 at 8:06 a.m., residents #20 and #58 stated their hashbrowns were cold. During an observation and interview on 2/9/26 at 8:07 a.m., staff member T stated the oven in the kitchen had been broken three times in the last month and they were aware of many residents complaining of cold food. The temperature of the hashbrowns located on the plate sitting in the food window was 110 degrees Fahrenheit. The biscuit was at 66 degrees. Staff member T stated the kitchen was waiting on parts again and stated it was very difficult to keep all of the food warm. Staff member T stated the corporate company was aware and had been ordering custom parts because the oven was so old and it kept breaking. Staff member T stated the right side of the oven won't stay lit whatsoever. Staff member T opened the oven, took the racks out and pointed to the lighter in the bottom of the oven. Staff member T stated this was the part that had not worked and stated he had the left side of the oven on 450 degrees all day every day in order to heat all the food. He stated he would have to start cooking tater tots served for lunch at 9:30 a.m. in order for them to get done on time.During an interview on 2/10/26 at 8:47 a.m., staff member D stated the administrative staff were aware of cold food concerns. Staff member D stated there were no known concerns of cold food in residents' rooms, but staff member D stated there could be the potential for the food to get cold in the carts. Staff member D stated so many residents liked to eat in their rooms since covid.During an interview on 2/10/26 at 12:50 p.m., residents #58 and #24 stated their food was often cold including the food they were served for lunch.During an interview and observation on 2/10/26 at 1:00 p.m., staff member U took the temperature of a cold pasta salad and it showed 45 degrees Fahrenheit. Staff member U stated they felt it should have been colder. Staff member U stated I agree it could be warm due to the large bin of pasta salad sitting on top of the ice instead of sitting in an ice bucket.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility leadership failed to maintain a QAPI system to identify quality of care and quality of life deficient practices, and show how deficiencies were identified, tracked, corrected, and monitored. The facility was cited with 17 deficiencies during the survey. These failures had the potential to affect all the residents of the facility due to needed corrections not being identified and addressed by the facility. Findings include: During an interview on 2/10/26 at 10:40 a.m., staff member A stated the facility talks about QAPI every morning. Staff member A stated, We go through the processes, and QAPI is involved in identifying deficiencies at morning meetings. Staff member A stated that the facility found they were not tracking improvement measures. Staff member A stated they had a performance improvement project regarding moving the coffee cart from the dining room to behind the nurses' station due to the potential for contamination. Staff member A stated that this project had been open for a while. Staff member A stated that, because of the survey, they have identified falls, med storage, med error rate, central supply, and food temperatures as concerns. Staff member A stated that the facility's Governing Body monitors the QAPI from outside the facility and provides feedback. Review of the facility policy, titled Quality Assurance and Performance (QAPI) Plan showed .the administrator is responsible and accountable to our corporation for ensuring that QAPI is implemented throughout our organization . When the need is identified, we will implement corrective actions plans or performance improvement projects to improve processes, systems, outcomes, and satisfaction . The goal of this committee is to aim for the highest levels of safety, excellence in clinical interventions, resident and family satisfaction and management practices . The scope of our QAPI program encompasses all service lines at [facility] including post-acute care and long-term care .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 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 observation, interview, and record review, the facility failed to ensure staff followed hand hygiene practices for glove changes during a dressing change and failed to ensure a clean barrier was put down to keep the supplies clean for 1 (#49) of 27 sampled residents. Findings include:During an observation on 2/9/26 at 10:04 a.m., staff member M was performing wound care and a dressing change on resident #49's coccyx. Staff member M placed the dressing change supplies on the resident's wheelchair but didn't place a clean barrier between the wheelchair and the supplies. Staff member M donned a gown, mask, and gloves due to enhanced barrier precautions. Staff member M removed the dressing from the resident's coccyx and discarded the dressing in the garbage. Staff member M removed her gloves. Staff member M had not used hand sanitizer or washed her hands before donning clean gloves. Staff member M donned clean gloves. Staff member M cleansed the resident's wound with wound cleanser. Staff member M removed her gloves. Staff member M donned clean gloves. Staff member M did not sanitize or wash her hands before putting on clean gloves. Staff member M put on clean gloves and applied a clean dressing to the wound on the resident's coccyx. Staff member M removed the gloves, gown, and mask before leaving the room.Staff member M had not sanitized or washed her hands between glove changes. Staff member M had not established a clean barrier for the supplies to change the residents' dressing.During an interview on 2/9/26 at 10:30 a.m., staff member M stated she had not washed her hands or used hand sanitizer between glove changes but would from now on.During an interview on 2/10/26 at 10:09 a.m., staff member C stated the expectation for hand washing or sanitizing was before the staff went into a resident's room, after patient contact, and before leaving the room.Review of the facility document, titled Hand Hygiene Table, showed staff were to wash hands or use hand sanitizer before applying and after removing personal protective equipment (PPE), including gloves.Review of the facility policy, titled Hand Hygiene, showed .7. a. the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a comfortable environment or temperature in the dining room and hallways of the facility for 1 (#49); and the resident was often cold and uncomfortable; and the facility failed to provide a homelike environment for 1 (#59) of 27 sampled residents, and resident #59 was frustrated with the layout of the room and the clutter. Findings include:1. During an interview on 2/8/26 at 9:49 a.m., resident #49 stated the dining room and hallways in the facility were often very cold so she ate in her room.During an observation and interview on 2/8/26 at 10:05 a.m., staff member J was wearing a coat and stated the temperature in the building was often cold.During an observation on 2/9/26 at 3:35 p.m., the thermometer on the wall in the back of the dining room showed 66 degrees Fahrenheit.During an interview on 2/9/26 at 3:42 p.m., staff member O stated the temperature of the building fluctuated a lot and in relation to the temperature outside.During an interview on 2/9/26 at 4:09 p.m., staff member N stated the dining room was often cold and they thought it could be from the large number of windows in that area.During an observation on 2/10/26 at 8:26 a.m., the dining room thermometer showed 64 degrees Fahrenheit.During an interview on 2/10/26 at 10:00 a.m., staff member L stated it was often super cold in the dining room area.2. During an interview on 2/7/26 at 3:08 p.m., resident #59 stated she wished she could have her bed turned around to see outside. She stated she was paralyzed from the waist down and was unable to ambulate or move out of the bed. Resident #59 stated she enjoyed looking outside. Resident #59 stated she also had asked the facility when she was admitted (admission date was 9/5/25) to hang up her picture frames. Resident #59 stated she was going to have her friends visit and she wanted her space to look presentable and feel like home to her. She stated she had asked the floor staff and the management staff about hanging up her pictures, but this task was not done for weeks. Resident #59 stated she often felt the staff members would say they would, . get to it by the end of the week, but that never occurred. Resident #59 also pointed to her cluttered bedside table, and stated it made her feel irritated how messy her room was in general. She stated she was unable to get up herself and organize or clean the area but rather had to rely on staff to help her.During an interview on 2/9/26 at 4:09 p.m., staff member N stated there was no reason why resident #59 could not have her bed turned around to look outside. They stated resident #59 might not be able to see much because of the hill outside of her window, but there could be a conversation about a room change.During an interview on 2/10/26 9:27 a.m., staff member D stated resident #59's pictures were not hung up because the resident did not want her pictures hung up with command strips. Staff member D stated it was offered, but they ended up putting in a maintenance request as some of the pictures were very heavy and required drilling.During an interview on 2/10/26 at 9:52 a.m., resident #59 stated the maintenance staff member had not hung up her pictures, but her friends had when they visited her. She stated the pictures had been sitting against her wall for three weeks and the friends hung all of the pictures up for her.Request for the homelike environment policy was made on 2/10/26. The policy was not received as of the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure facility staff received hands on BLS certification. This deficient practice placed residents at risk of failed CPR for full code residents and respiratory distress treatment during an emergency, if necessary. Findings include:Review of all staff BLS certifications showed all staff members except for one were certified through the National CPR Foundation, which did not provide a hands-on training.During an interview on [DATE] at 1:22 p.m., staff member P stated they participated in a CPR class at their current position, but the class was entirely online, and it did not consist of any hands-on training. Staff member P stated they went over what CPR was and some basic first aid training but never completed any compressions on a dummy or received feedback on their CPR performance. Staff member P stated they had previous experience from another job where they were required to do BLS. Staff member P stated they felt relief knowing they had that prior experience because they may need it in their current position.During an interview on [DATE] at 1:29 p.m., staff member N stated their CPR certification was done completely online and there was no hands-on experience.Review of staff members P and N's certifications showed: Healthcare - CPR/AEDReview of the State Operations Manual, revised [DATE], showed: . Facility policies should address the provision of basic life support and CPR, . CPR Certification Staff must maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards.References:American Red Cross. (2026). Retrieved from https://www.redcross.org/take-a-class/online-safety-classes/all-online-classesAccording to the American Red Cross, . CPR stands for cardiopulmonary resuscitation. It can help save a life during cardiac arrest, when the heart stops beating or beats too ineffectively to circulate blood to the brain and other vital organs. BLS stands for Basic Life Support. This certification course trains healthcare clinicians including nurses, physicians, EMS professionals, and other healthcare and public safety personnel to respond to breathing and cardiac emergencies in adults, children and infants. (American Red Cross, 2026).Also, according to the American Red Cross, online training is, . Perfect for those who want the freedom to take self-paced courses, our online classes can help you learn what CPR is and how to perform the different types of CPR. However, online safety training courses do not allow you to demonstrate your skill proficiency to a certified instructor, and therefore your certification may not meet the requirements for workplace safety. (American Red Cross, 2026).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, the facility failed to maintain a medication error rate of five percent or less for 2 (#s 19 and 43) of 4 residents observed. The total number of medications observed was 28, with three errors noted for a total medication error rate of 10.71 percent. Findings include:During an observation and interview on 2/8/26 at 11:14 am, with staff member G, all medications for the morning shift had been pre-poured in eight cups in the top drawer of the cart from the morning pass. Staff member G stated that pre-pouring of medications at the beginning of the shift was common practice at the facility. Staff member G stated she was unable to describe what each medication was in the cups because she prepped them early in the morning, when she arrived on shift. Each cup had a name on it, but did not have the names of the medications in the cup. During an observation on 2/8/26 at 11:15 a.m., staff member G prepared medications for resident #43 for lunch pass. Staff member G opened a gabapentin 300mg capsule and placed the medication in pudding. Staff member G stated resident #43 had gabapentin put in pudding because the facility had difficulty with resident #43 not taking the medication in the past. Staff member G took the pills and the cup of pudding into resident #43 and administered the medications. After exiting the room, staff member G stated she was not aware that gabapentin was contraindicated for opening capsules for administration. Review of resident #43's gabapentin order, dated 2/8/26, did not reflect medication should be administered in pudding or opened. Review of resident #43's crush order, dated 10/23/24, reflected, May crush meds or open capsules as needed unless contraindicated. During an observation and interview on 2/8/26 at 11:25 a.m., staff member J stated all of her medications were pre-poured and prepped at the beginning of the shift for the morning pass. There were 11 cups remaining, lined up in the top drawer of the medication cart with the names of the residents on them, but no information on what was in the cups. Staff member J stated she would need to look up the resident's MAR to explain what was in the cup. Staff member J stated the cups were prepared at the beginning of her shift. The nurses' shifts start at 6 a.m. During an observation and interview on 2/9/26 at 7:22 a.m., staff member G prepared medications for resident #19. Staff member G would bring the cup down to the pill card in the 3rd drawer down to pop the pill into the cup. Staff member G popped a pill out of the card and a yellow oblong pill (pantoprazole 20 mg delayed release) popped out of the cup onto the floor. Staff member G continued to prepare medications, unaware of the medication on the floor. Staff member G locked up the cart and began to walk away to the resident #19's room. The surveyor stopped the medication pass and pointed out the medication on the floor to avoid a safety hazard. Staff member G stated she did not notice the medication had popped out of the cup. After clean-up and prepping a new dose of pantoprazole, staff member G entered the room of resident #19. Staff member G gave resident #19 her medications and handed resident #19 her Advair inhaler to use. Resident #19 used the inhaler and handed it back to staff member G. Staff member G then exited the room without having resident #19 rinse and spit after the use of the Advair inhaler. Staff member G stated she was not aware she needed to have residents rinse and spit after the use of Advair inhalers. Review of the Advair-Diskus manufacturer's patient information, revised 6/23, reflected that residents should rinse and spit after the use of Advair Disk. Review of the facility's policy, Administration of Dry Powder Inhalers, dated 5/9/25, reflected: - 13. Allow resident to rinse mouth with water when required per manufacturer recommendations and spit out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions in an effort to discontinue these drugs; and maintain documentation of gradual dose reduction failures for 2 (#s 8 and 43) of 27 sampled residents. Findings include: 1. Review of resident #8's, Consultant Pharmacist Recommendations to Prescriber, dated 9/24/25, reflected resident #8 was taking Buspirone, Abilify, and Citalopram without a gradual dose reduction. The pharmacist recommended a gradual dose reduction. The physician's response was: Disagree, guardian refuses GDRs due to past GDR failure.Review of resident #8's, Consultant Pharmacist Recommendations to Prescriber, dated 11/8/25, reflected resident #8 was taking Citalopram without a gradual dose reduction. The pharmacist recommended a gradual dose reduction. The physician's response was: Disagree, guardian refuses GDRs due to past failed GDR.Review of resident #8's Consultant Pharmacist Recommendations to Prescriber, dated 9/25/23, reflected resident #8 was taking Buspirone, Abilify, and Citalopram without a gradual dose reduction since 2/2022. The pharmacist recommended a gradual dose reduction. The physician's response was: Previous, in facility, GDR failure for behavioral symptoms related to dementia or use is in accordance with relevant current standards of practice for psychiatric disorder.During an interview on 2/9/26 at 2:21 p.m., staff member B stated the facility had no documentation of a failed GDR for resident #8 in the facility or outside the facility.2. Review of resident #43's Consultant Pharmacist Recommendations to Prescriber, dated 1/22/25, reflected resident #8 was taking Aripiprazole, Fluoxetine, Trazadone, and Hydroxyzine without a gradual dose reduction. The pharmacist recommended a gradual dose reduction. The physician's response was: Disagree: Previous, in facility, GDR failure for behavioral symptoms related to dementia.During an interview on 2/9/26 at 2:21 p.m., staff member B stated the facility had no documentation of a failed GDR for resident #43, in the facility or outside the facility. Staff member B stated resident #43 never failed a GDR.Review of the facility's policy, Gradual Dose Reduction of Psychotropic Drugs, dated 6/6/25, reflected:- Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure current PASRRs were completed for 3 (#s 13, 14, and 64) of 27 sampled residents. Findings include:1. Review of resident #64's EHR showed the diagnosis: post-traumatic stress disorder, dated 12/29/25.Review of resident #64's PASRR Level 1, dated 11/1/24, showed the diagnoses: bipolar disorder and major depressive disorder but failed to show post-traumatic stress disorder.2. Review of resident #14's EHR showed the diagnosis: major depressive disorder, dated 10/14/24.Review of resident #14's PASRR Level 1, dated 1/31/18, showed the diagnosis of mood disorder (not all inclusive). Resident #14's PASRR Level 1 failed to show major depressive disorder.3. Review of resident #13's EHR showed the diagnosis: residual schizophrenia, 11/19/25.Review of resident #13's PASRR Level 1, dated 1/25/24, showed the diagnosis: schizoaffective disorder, but failed to show residual schizophrenia as well.During an interview on 2/10/26 at 10:11 a.m., staff member C stated a new PASRR should have been completed for resident's #13, #14, and #64 due to the new diagnoses. Staff member C stated they were unaware of the new diagnoses and there was miscommunication from the MDS department concerning the new diagnoses.Review of a facility policy, titled Resident Assessment - Coordination with PASRR Program, dated 5/5/25, showed: . Negative Level I Screen - permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual disability arises later.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 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 ensure a resident was provided dignity by assisting the resident to change clothes and comb his hair, and the resident was not shaved and had body odor, for 1 (#18); and failed to provide basic ADL cares of a warm washcloth offered in the morning or provide the preferred number of showers, and the resident felt the staff did not prioritize her care or check on her enough so she would go without services, for 1 (#59) of 27 sampled residents. Findings include:1. During an observation on 2/7/26 at 3:59 p.m., Resident #18 looked disheveled with unshaven whiskers and had a foul odor. The resident's room was dark and had the smell of body odor. During an observation on 2/8/26 at 8:13 a.m., resident #18 looked disheveled and in the same clothes as yesterday and his hair was not combed. Whiskers were observed on his face. The whiskers were an increased amount from the previous day. During an interview on 2/10/26 10:55 a.m., staff member C stated staff should offer showers, wash the resident's face and comb the hair, and attempt to get them to comply or encourage them to assist in cleaning themselves and changing clothes. During an observation on 2/10/26 at 11:03 a.m., resident #18 was lying in bed. The resident's appearance was disheveled. During an interview on 2/10/26 at 11:07 a.m., staff members K and L stated resident #18 kept to himself. Staff members K and L stated the resident came to the facility on hospice. Staff members K and L stated the resident had a stroke after admission. Staff members K and L stated that the resident stayed in bed most of the time. Staff members K and L stated the resident was given a bath on Wednesdays from hospice. Review of resident #18's care plan, initiated on 12/5/25, showed the resident was a one-to-two person assist for showering and bathing, one person assists for personal hygiene, and one person assist for dressing. Review of resident #18's hospice coordinated plan of care, with a start date of 12/1/25, showed a hospice aide was coming to the facility on Wednesdays to assist with bathing and personal hygiene. Review of a document, titled Showers, showed resident #18 was to have showers on Tuesdays and Fridays. 2. During an interview on 2/7/26 at 3:08 p.m., resident #59 stated she was paralyzed from the waist down, so she relied on the staff's help for ADL care. She started to cry and stated, I don't want to be negative, but she stated she felt the basic cares were frequently missed. During an interview on 2/9/26 at 3:56 p.m., resident #59 stated that the last time she was offered a warm washcloth to wash her face and offered to brush her teeth by a staff member was last Friday. She stated it was last Sunday when she was last offered a bed bath, which was also by hospice. She stated the staff members would never offer her a warm washcloth or toothbrush but stated I would like it. She stated she felt the staff members did not prioritize her care or double-check on her when needed. Resident #59 also stated she received one bed bath a week but wanted two bed baths. She stated it was maybe her fault for not asking hospice for more showers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #59's EHR showed a task: Shower every Wed AM (hospice) and Sunday PM. Review of resident #59's EHR showed resident #59 was given four bed baths in the last 30 days (1/28/26, 2/1/26, 2/4/26, and 2/8/26). Review of a facility policy titled, Activities of Daily Living (ADLs), not dated, showed: . Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care . Review of a policy, titled Promoting/Maintaining Resident Dignity, date of review was 5/16/25, showed .1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observations, interviews, and record review, the facility failed to ensure a resident received the level of assistance needed related to a hearing loss and communication deficits, for 1 (#70) of 27 sampled residents. The resident's care plan did not include interventions staff could use to alleviate or assist with the resident's communication frustrations or deficits. This deficient practice created frustration for resident #70 while trying to communicate with others. Findings include: During an observation and interview on 2/8/26 at 7:24 a.m., resident #70 was lying in bed with the lights on. Resident #70 was very hard of hearing, asking the surveyor to get very close to his face and speak loudly to be heard. Resident #70 stated he had not been offered any form of amplifier or communication boards to assist in communicating with others. Resident #70 became frustrated while speaking with the surveyor because he could not hear the questions. The interview was ended early to allow resident #70 to rest. Resident #70 stated he would be willing to use an amplifier (pocket talker) to assist in hearing others, if offered. During an interview on 2/9/26 at 1:20 p.m., staff member E stated she had not considered a pocket talker for resident #70. Staff member E stated resident #70 had refused a full evaluation, but she was aware he was very hard of hearing. During an interview on 2/9/26 at 1:53 p.m., staff member E stated occupational therapy had taken resident #70 a pocket talker, and he was successfully using the pocket talker to communicate. Review of resident #70's Care plan, updated 2/4/26, reflected resident #70 had impaired communication related to hearing loss. The care plan reflected two interventions: one to identify specific communication barriers (dated 3/3/25) and the other to order debrox solution per physician order (dated 11/20/25). The care plan did not include interventions for staff to use to assist the resident with his daily communication or hearing deficit. Review of the facility's policy, Use of Assistive devices, dated 5/30/25, reflected: -3. The facility will provide assistive devices for residents who need them. Nursing, dietary, social services, and therapy departments will work together with the resident and responsible parties to ensure availability of devices .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interventions were implemented based on the care plan and person-centered to prevent on-going falls for 1 (#15); and offer assistance with ambulation to the toilet for 1 (#49) of 27 sampled residents. This deficient practice resulted in resident #15 having eight falls in six months and placed resident #49 at risk of additional falls. Findings include:1. During an observation and interview on 2/9/26 at 4:13 p.m., resident #15 was lying in bed, with a tray table next to the bed with personal items on the table. NF1 was visiting resident #15. Resident #15 was not responsive to an introduction or interview questions. NF1 stated resident #15 had many falls since he had been at the facility. NF1 stated she did not understand why resident #15 was at the end of the hall, away from the nurses and CNA staff. NF1 stated that there used to be a one-to-one in the hallway watching him and another resident a couple of weeks ago. NF1 stated that the resident was no longer at the facility, which removed the one-to-one staff. NF1 stated she was concerned about more falls occurring. NF1 stated resident #15 had a walker he brought from home, but it was no longer in his room. The call light was pinned to the edge of the bed near his head. During an interview on 2/9/26 at 4:28 p.m., staff member H stated resident #15 was too weak to use his walker and the walker was removed. Staff member H stated he was not aware of where the walker went and resident #15 required total assistance to the toilet. During an interview on 2/9/26 at 4:36 p.m., staff member I stated resident #15 became more disoriented with the room move. Staff member I stated resident #15 required total care for toileting and hourly checks. Review of resident #15's MDS, dated [DATE], reflected resident #15 had a BIMS of 3 (severe impairment). Review of a facility report, Incidents by Incident type, dated 8/9/25 - 2/9/26, reflected that resident #15 had fallen eight times in six months. Review of individual fall reports provided by the facility for the falls, dated 12/24/25 - 1/8/26, showed: - On 12/24/25, resident #15 attempted to transfer from his bed and ambulate while stabilizing himself on the bedside table. Interventions for fall prevention included removal from the room and a bed positioning bar at the end of the bed, - On 1/2/26, resident #15 tripped over his oxygen tubing, causing him to fall. Interventions for fall prevention included call light education, and the call light was pinned next to his hand for assistance prior to transferring, and monitor for bleeding and encourage the resident to go to the hospital for x-rays, - On 1/7/26, resident #15 fell while using his bedside table as a walker to ambulate. Interventions for fall prevention included removal of the bedside table and a TV tray to be set up for meals and removed upon the end of the meal and stowed away; and, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 2/2/26, resident #15 fell while attempting to self-transfer to the toilet without using the call light for assistance. Interventions for fall prevention included educating the resident to use the call light and adding glow in the dark duct tape to the call light for a visual reminder. Review of resident #15's Care Plan, dated 2/4/26, reflected the last care plan review was completed on 12/4/25. The care plan reflected that resident #15 was at risk of falls related to debility/generalized weakness and lack of confidence in ability. Interventions included assessing for adaptive equipment, fall assessment per protocol, notifying the physician if needed, referring to physical therapy and occupational therapy for strengthening exercises and gait training, and a scoop mattress to help with his fall risk. The care plan did not include interventions that direct care staff could use daily to help the resident prevent the ongoing falls. The care plan for falls was not updated with interventions from the most recent falls. Review of resident #15's Fall Risk Assessment, dated 12/22/25, reflected resident #15 was at moderate risk of falls related to a history of falls, medications, incontinence, use of a walker, and memory. Review of resident #15's Fall Risk assessment, dated 1/1/26, reflected resident #15 was at high risk of falls related to history of falls, medications, memory, incontinence, and gait/balance deficits. During an interview on 2/9/26 at 1:20 p.m., with staff members A and B, staff member B stated resident #15 had a low BIMS, and the facility was working to address his falls. Staff member B stated the education interventions with a resident who had a low BIMS should have reflected reminders and not education. Staff member A stated that resident #15 was put at the end of the hall because another resident was receiving one-to-one supervision at the time and the staff member was keeping an eye on both residents. Staff member A stated the facility had not looked at resident #15's room placement since the one-to-one was discontinued. Staff member B stated the bedside table should not be at the bedside for any reason other than a meal and should have been removed after the meal. Staff member B stated the call light should be near resident #15's hand rather than his head. 2. During an interview on 2/8/26 at 9:49 a.m., resident #49 stated she was new to this facility but was known to fall. She stated staff members sometimes took a long time to respond to her call light. Resident #49 stated she would wait and wait until you just can't wait anymore. Resident #49 stated she would put her call light on, wait a few minutes and then ambulate herself to the restroom because she was afraid of an accident if she did not make it to the restroom on time. During an observation and interview on 2/10/26 at 8:40 a.m., resident #49 stated she was going to transfer from her bed to her wheelchair as she needed to use the restroom. Resident #49 stated she would wait a few minutes and continued to look outside of her door for staff members to help. Staff member V's medication cart was located right outside of resident #49's room. Staff member V stated they would wait for a CNA to help resident #49 as they were preparing medications. Staff member V called for staff member Q to help resident #49 and stated they would only stop doing medications if resident #49 was getting up without anyone's help. Resident #49 got up, pivoted to her wheelchair, and wheeled into the bathroom. Staff member V was aware of resident #49's ambulation and kept preparing medications. Staff member Q arrived, walked into resident #49's room for a moment, saw the resident had already made it to the restroom, exited the room and stated to staff member V she (resident #49) is the most impatient. Review of resident #49's EHR, there were five nursing notes, dated 2/9/26, 2/8/26, 2/6/26, 2/4/26, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/2/26, which showed resident #49 . is a high fall risk . Review of the facility's policy, Fall Prevention Program, dated 5/29/26, reflected: - Each resident will be assed for fall risk and will receive care and services in accordance with their level of risk to minimize the likelihood of falls. -5. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to: .iii. Call light and frequently used items are within reach., a- High Risk Protocols: .c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. [sic]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to consistently provide pain relief by repositioning for 1 (#59) of 27 sampled residents. This deficient practice resulted in resident #59 reporting moderate pain when repositioning was not provided. Findings include:During an interview on 2/7/26 at 3:08 p.m., resident #59 stated she would experience pain at a level of 6 out of 10 (on a zero to ten pain scale) when she needed to be repositioned. Resident #59 stated she would wait 15 minutes, in agony because she needed to be repositioned. She stated her pain usually occurred in her legs because they would often sit in the same position for a long period of time. She stated the wait was the worst during the dining times because all of the staff were moving residents down to the dining room to eat.During an interview on 2/10/26 at 2:02 p.m., resident #59 stated she had pain this morning around breakfast because she waited 20 to 25 minutes for a staff member to respond to her call light. She stated she felt frustrated because this happened a couple of times a week.Review of a nurses note, dated 2/8/26, showed: Resident #59 continued to complain of muscle pain and cramps in her legs and elbows. The note also showed: Voltaren gel applied x2 (two times) throughout the night and nurse helped reposition . [sic]Review of resident #59's Care Plan, dated 9/5/25, showed: . Repositioning: frequently for comfort . Review of a facility policy, titled Pain Management, dated 5/1/25, showed: . 6. Non-pharmacological interventions may include but are not limited to: . d. Physical modalities . turning and repositioning .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observations, interviews, and record review, the facility failed to offer dental services for 1 (#11) of 27 sampled residents. This deficient practice resulted in resident #11 feeling he could not chew his food and having coughing episodes while eating. Findings include:During an interview on 2/8/26 at 8:27 a.m., resident #11 stated the food was not the best. He stated he was unable to eat the food or swallow many of the foods because he did not have any teeth. He stated he was afraid he would swallow it and choke. Resident #11 stated he had not been to the dentist before, but would like to go in order to get dentures. Resident #11 stated that dental services were not offered to him.During an interview and observation on 2/9/26 at 8:16 a.m., resident #11 stated he felt safe swallowing oatmeal but stated he never ate the food on his plate because he choked on it. As resident #11 was eating his oatmeal, his legs were positioned off the bed, but his upper body was leaning back against the wall behind him. Resident #11 coughed multiple times. Resident #11 stated he was having a hard time swallowing. During an interview on 2/10/26 at 1:09 p.m., staff member W stated there were many residents, including resident #11, who feared going out of the building, and that could be why a dental appointment was never made for resident #11.Review of a survey documentation request on 2/9/26 at 11:50 a.m., showed: Dental referral/notes/etc. for resident #11. No documentation was provided for this request by the end of the survey.Review of a facility policy titled, Dental Services, dated 6/15/25, showed: . ?Routine dental services' means an annual inspection . 1. The dental needs of each resident are identified through the physical assessment and MDS assessment processes and are addressed in each resident's plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on interview, observation, and record review, the facility failed to identify a swallowing issue, hear the resident's concerns, notify the speech language pathologist, and properly address swallowing concerns for 1 (#11) of 27 sampled residents. This deficient practice has the potential to result in weight loss or choking if not identified and addressed timely. Findings include:During an interview on 2/8/26 at 8:27 a.m., resident #11 stated the food was not the best. He stated he was unable to eat the food or swallow many of the foods because he did not have any teeth. He stated he was afraid he would swallow it and choke. Please see F791 for dental concerns.During an interview on 2/9/26 at 9:05 a.m., staff member M stated there could be a swallowing issue with resident #11, but there was currently not an issue that they knew about.During an interview and observation on 2/10/26 at 8:33 a.m., resident #11 had his dinner tray left in his room from the prior evening meal on 2/9/26. Resident #11 stated that no staff members had helped him set up the meal/tray or help him sit up so he could eat. Review of resident #11's Care Plan, dated 5/5/25, showed: . eating assistance of: set up trays .During an observation and interview on 2/10/26 at 8:34 a.m., staff member Q stated that resident #11 did not need help with the setup of food, sitting up to eat, and did not need a reminder to sit up to eat. Staff member Q stated resident #11 did have some trouble swallowing at times, but stated it was nothing significant.During an interview and observation on 2/9/26 at 8:16 a.m., resident #11 stated he felt safe swallowing oatmeal, but stated he never ate the food on his plate because he often choked on it. Resident #11 stated he hardly looked underneath the plate warmer because he knew he would not be able to eat it. As resident #11 was eating his oatmeal, his legs were positioned off the bed, but his upper body was leaning back against the wall behind him. Resident #11 coughed multiple times. Resident #11 stated he was having a hard time swallowing. Resident #11 stated sometimes he ate sitting upright in the chair, but not always. Resident #11 stated that no staff had advised him to sit up or sit in his chair to eat his meals.During an observation and interview on 2/9/26 at 8:51 a.m., resident #11 stated he was able to drink fluids with no issues. He stated he coughed on the blueberry bread, so he stopped eating. He stated he was a little bit still hungry. Resident #11's tray had a few bites out of the blueberry bread and the oatmeal. Resident #11's tray also had pureed eggs located underneath the plate warmer that were untouched.Review of resident #11's physician order, dated 11/20/25, showed: regular diet, soft bite-sized texture . per patient request (okay to have regular bread products) for nutrition.During an interview on 2/9/26 at 1:54 p.m., staff member E stated they had not heard of resident #11 having any swallowing issues from any staff members. Staff member E stated if there was an issue, staff members should report it to them. Staff member E stated they remembered putting the order in for resident #11, and they did not remember including per patient request. Staff member E looked into the audit order and showed that staff member A changed the order.During an interview on 2/9/26 at 3:31 p.m., staff member E stated, I would have loved to know that (resident #11 had troubles swallowing). Staff member E stated they were unaware and were now going to reevaluate resident #11. Staff member E stated coughing could be a protective measure when eating and was not always concerning.During an observation and interview on 2/10/26 at 10:23 a.m., staff member N stated resident #11 was able to swallow a soft and bite-sized diet, and they were unaware of any concerns. Staff member N fed a piece of a cookie to resident #11 as he was lying down in his bed with the head of his bed at about a 30-degree angle. Resident #11 chewed and appeared to swallow the cookie, but stated, No when asked if he swallowed the cookie. Resident #11 swallowed a few more times, including one audible swallow, and stated, No, he was still unable to fully swallow the cookie. Staff member N gave resident #11 a sip of water. Resident #11 still replied that he was unable to swallow the cookie fully. Staff member N then mentioned that resident #11 should sit up at the edge of the bed. Resident #11 then stated he was able to swallow the cookie all the way. Staff member N stated resident #11 was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognizant and more than capable of knowing if he was not swallowing well.Review of resident #11's BIMS (Brief Interview of Mental Status) showed a 13, cognitively intact.Review of resident #11's Care Plan, updated 5/5/25, showed resident #11 was edentulous (medical term referring to the loss of all natural teeth). The care plan failed to include any interventions related to swallowing concerns or deficits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275056	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhorn Healthcare and Rehabilitation	474 Hwy 282 Clancy, MT 59634

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was properly monitored, marked, and thrown away in a reasonable amount of time to prevent the growth of bacteria. Findings include:During an observation and interview on 2/7/26 at 11:35 a.m., the following items were observed in the kitchen:- The chicken gravy mix and the country style gravy had no open date,-The [NAME] classic (one full and one opened bag) and Roseli egg noodles (one full and one opened bag) did not have an open or receive date,-Five slices of deli turkey with the date 12/5 written on the bag in the fridge,-No prepared or discard date on the lemonade in a pitcher in the fridge,-No open date on the cranberry juice in the fridge,-In the room tray cart, there were 14 prepared servings of peach parfait that was scheduled to be served for lunch. The food was not covered or chilled. The container was warm to the touch.Staff member X stated there should have been a green receive date sticker and a written open date on any opened items. Staff member X stated the peach parfait should have at least been covered. Staff member X stated they felt impartial if the food was required to be chilled or not.Review of a facility policy, titled Date Marking for Food Safety, not dated, showed: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for food safety. 1. Refrigerated, ready-to-eat, time/temperature control for safety food . shall be held at a temperature of 41 degrees Fahrenheit for a maximum of 7 days.