STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275061	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan Health Care Center - Shelby	630 Park Drive Shelby, MT 59474

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to address resident needs in a timely manner for 1 (#4) of 14 sampled residents, causing resident #4 to feel embarrassed and unimportant. Findings include: During an observation and interview on 5/5/25 at 1:51 p.m., resident #4 was sitting up in her bed watching television. Resident #4 stated she was currently unable to get out of bed because she had another hip fracture. Resident #4 stated she had broken both of her hips within the last year because of prolonged steroid use. Resident #4 stated her left hip was currently fractured. Resident #4 stated she had an incident in September that had upset her. Resident #4 stated she had pushed the call light so she could get assistance to the bathroom. Resident #4 stated staff member D came into her room turned off the call light and asked her what she needed. Resident #4 stated she had let staff member D know that she needed to use the bathroom. Staff member D told her that he was in the middle of providing care for another resident but would be back to help her. Resident #4 stated, I ended up waiting for a very long time, and because of that I ended up urinating in my bed. I was so embarrassed. I felt like I was not important enough and that my needs were not important. At that time, I was not on bed rest, and I could get to the bathroom with help, there was no excuse for it. Review of a Facility Reported Incident submitted to the State Survey Agency on 9/23/24, showed resident #4, Had rang her light to be assisted to the bathroom. The CNA came in and stated he was busy with another resident and would be back. When the CNA came back to assist the resident she had soiled herself. Review of the Facility Reported Incident final report, submitted on 9/26/24, showed, CNA responded to the resident's call light and told her he would be back. The CNA did return, but after the resident had soiled herself. The CNA received education. During an interview on 5/5/25 at 7:15 p.m., staff member D stated he was fairly new to the facility at the time of the incident. Staff member D stated he was on shift with another staff member at the time. Staff member D stated resident #4 had put her call light on and asked for assistance to the bathroom. Staff member D stated he told resident #4 he was in the middle of providing cares for another resident but would find someone to help her. Staff member D stated there was no one else to help her at the time. Staff member D stated resident #4 put her call light back on and when he was finished with cares for the other resident he went back into her room. When staff member D entered the room, resident #4 told him she had been incontinent of urine. Staff member D stated he provided incontinent care to resident #4, and resident #4 was upset by the incident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document titled, Social Services of [Facility Name], BHSS286, with an effective date of 4/2024, showed: . 2. Dignity: Every resident is treated with dignity and respect, . fostering an environment where they feel valued, heard, and understood.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During an observation on 5/6/25 between 7:57 a.m. and 8:54 a.m., resident #8 was observed during breakfast. The resident was seated at a table with three other residents. The resident had fluids to drink and was noted to be coughing during the meal. The resident had a difficult time keeping food on her fork. The resident appeared to be sleeping in between bites. The resident had not received any assistance or cueing from staff. The staff were in and out of the dining room assisting residents out of the dining room. There were periods of time when there were not staff monitoring residents in the dining room. Resident #8 received cueing from a resident seated next to her. The resident would pat her on the arm and encourage her to eat. During an observation on 5/7/25 from 7:53 a.m. to 8:34 a.m., resident #8 was observed in the dining room for breakfast. The resident was approached by staff at 8:05 a.m. and asked if she wanted her food cut up. The staff member then cut up the bacon the resident had on her plate. The resident also had blue berry cake, scrambled eggs and cut up cantaloupe. The resident was having a difficult time getting the food to stay on her fork. Staff reminded her to chew her food. At 8:21 a.m., the resident was noted to be coughing while eating. At 8:25 a.m., the resident was noted to be holding food in her mouth without chewing movements. At 8:27 a.m., resident #8 was noted to be coughing. During an interview on 5/6/25 at 7:59 a.m., staff member M stated there had been a modification to resident #8's diet. Staff member M stated the resident had a swallow study done. Staff member M stated resident #8 does have difficulty with swallowing. Staff member M stated the resident started with a pureed diet. Staff member M stated staff observed the resident and her diet was advanced as she could tolerate. Staff member M stated the resident was observed each time the diet was advanced to ensure no choking occurred. During an observation on 5/7/25 at 12:27 p.m., resident #8 was assisted to eat by staff. During an interview on 5/7/25 at 1:31 p.m., staff member H stated resident #8 has had a lot of dietary changes. Staff member H stated there was always staff in the dining room. Staff member H stated the resident was to have her food cut into small pieces. Staff member H stated the resident was to be monitored during mealtime. Staff member H stated the resident received assistance with eating today. Staff member H stated there had not been any modifications of silverware. During an interview on 5/7/25 at 2:26 p.m., staff member B stated we reduced the portions of food, as the amount of food appeared to be overwhelming. Staff member B stated after the esophogram procedure the facility put the resident on a pureed diet. Staff member B stated when the resident appeared to tolerate the pureed diet, they then advanced her diet. Staff member B stated they then waited until the resident tolerated the advanced diet, then the facility advanced her diet until they reached a regular diet with cut up foods. Staff member B stated she thought the resident was doing better. Staff member B stated the staff were not to rush the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a reportable incident to the State Survey Agency, dated 1/16/25, resident #8 was observed to choke on a piece of cauliflower. Findings, submitted on 1/22/25, showed the resident was choking and staff had to administer the Heimlich Maneuver to free the resident's airway. The resident's food was cut into smaller pieces, and the resident was monitored for complications and safety. Staff member M evaluated the resident's diet and the provider ordered a bite-sized diet. Review of a report, titled XR esophagus study, dated 1/29/25, showed resident #8 had suspected mild esophageal dysmotility noted by delayed passage of contrast with pooling in the distal one third esophagus. Review of resident #8's Progress Notes showed on 2/10/25, the resident started coughing on some cottage cheese and later vomited and had to change her top due to the incident. On 2/11/25 the resident had a choking episode and the resident stated the food she swallowed does not go all the way down and it made her cough and vomit. On 4/4/25 the resident had tolerated the pureed diet and was advanced to easy to chew food. On 4/15/25, the resident was advanced to a soft and bite sized diet. Review of resident #8's Care Plan, with an initiated date of 2/12/25, showed the resident had a decreased ability to swallow and often coughs at mealtimes. Per the swallow study, the resident does have slow swallow and pockets foods in her throat at times. She often ends up vomiting during meals when coughing often. Interventions included, move to table closer to staff when eating so she can be monitored, offer food in small portions, one at a time. Cut food into bite size portions, remind the resident to slow down when eating and to tuck her chin when swallowing, trial of pureed food, and cue the resident throughout the meal to continue eating. There were no new interventions for advancement of the resident's diet. Based on observations, interviews, and record review, the facility failed to provide the safest environment possible for 1 (#2) of 14 sampled residents. This deficient practice resulted in a resident's fall with major injury; and failed to ensure a resident with a history of choking was monitored closely by staff to ensure the resident did not choke on foods, for 1 (#8) of 14 sampled residents. Resident #8 had a choking episode which required the Heimlich Maneuver be performed and continued to cough during meals. Findings include: During an observation on 5/05/25 at 12:36 p.m., resident #2 was lying in bed, eyes were closed, and the call bell was sitting on his chest; a bruise was noted on the left jaw area; a wound was noted on the left side of the back of his head; there was no floor mat next to the bed, and the bed remote was inside the drawer of the nightstand. During an interview on 5/05/25 at 12:43 p.m., staff member J stated, I heard ten different stories about his (resident #2) fall last week, the night CNA said his (resident #2) bed was left up all the way as far as it could go, and the bed control was in the bedside drawer that night, at shift change they knew his bed was up . Staff member J did not feel comfortable stating which staff member shared the information about the bed being left in the up position. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/05/25 at 2:25 p.m., NF2 and NF3 stated the report they received from the facility (regarding the fall) was that he (resident #2) was playing with his bed remote, and he (resident #2) raised the bed to the highest position possible, and then fell out of bed. NF2 stated the bed remote was always in the drawer, I've never seen it (bed remote) out of the drawer except maybe once since he's been living here (2019 to present). NF2 stated they heard different versions of what happened regarding his (resident #2) fall, and was concerned, But I guess it was just an accident. During an interview on 5/05/25 at 7:19 p.m., staff member D stated he was charting at the nurse's station when resident #2 fell. Staff member D stated when he got to resident #2's room, the bed was all the way up, and the bed remote was on the floor when, normally it is in the drawer of the nightstand where he cannot reach it. Staff member D stated he made sure the bed remote was always in the drawer, especially when I see him, I make sure he doesn't have it; it's the only time he's ever had it since I started working here in June of 2024. During an interview on 5/05/25 at 7:34 p.m., staff member E stated, I was passing meds when I heard a thud, and I knew it was him (resident #2); when I got to the room, the bed was high; I think he had the bed control and was playing with it; I don't think an employee did it; the remote is normally kept over bedside table or in the drawer, I don't know how he got it. Staff member E stated, We have new people, I think he had the remote that night; I think he had the remote from whoever was in there last. Staff member E stated she did not receive education on fall prevention or were there any new fall prevention interventions initiated after resident #2's fall by her or the facility. During an observation on 5/06/25 at 8:43 a.m., a fall mat was not present in resident #2's room. During an interview on 5/06/25 at 11:06 a.m., staff member B stated the evening staff took the remote away (from resident #2) because he kept raising and lowering his bed with it. Staff member B stated they were not allowed to take the bed remote away because, He has a right to fall. During an interview on 5/06/25 at 11:21 a.m., staff member F stated CNAs and nurses know the fall prevention interventions on resident #2's care plan and kardex, I make sure they know. During an interview on 5/06/25 at 1:09 p.m., staff member K stated during evening rounds with the oncoming CNA prior to resident #2's fall, he suggested more frequent rounding because resident #2 had raised his bed with the bed remote and was trying to get up. Staff member K stated he did not take the bed remote from resident #2, and it was also the first time he had ever seen resident #2 using the bed remote. Staff member K stated NF2 had asked him questions regarding the fall, and staff member K explained he had, heard a couple of different stories and scenarios, which might have caused him (resident #2) to fall including: He raised the bed himself with the bed remote, and also a CNA left the bed up after evening cares, but he couldn't remember which CNA told him this information. During an observation on 5/06/25 at 1:25 p.m., a fall mat was present in resident #2's room. During an interview on 5/06/25 at 2:35 p.m., NF 2 stated, I don't think he could have moved his bed up and down, or be able to get to the bed remote, I've never even seen him with it, he can't even use the TV remote. Review of a facility document titled, Purposeful Post-Fall Huddle, dated 4/27/25, included with resident #2's fall investigation packet, showed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	.Root Cause(S):1. Resident raising bed on own, 2. Resident confusion .Action Plan: What could be done to avoid future falls (intervention)? left blank, Care plan updated? left blank . [sic] Review of a facility document titled, Progress Notes, page 7 of 23, dated 5/1/2025, e-signed by staff member F, showed: .The following initial interventions have been put in place to prevent future falls: fall matt on floor . [sic] Review of a facility document, titled, Care Plan History, created 12/2/2019, showed: .Changes Prior to Completion of Last Review, Description: [Resident] will not sustain serious injury through the review date, Target Date: 7/1/2025, Last Revision Date: 1/10/2025, Revision By: Staff member F . Review of a facility document, titled, IDT FALL REVIEW - V 3, dated 5/1/2025, with the following participants present: staff members F, B, and A, showed: .3. Describe initial interventions to prevent future falls: fall matt on floor . [sic] Review of a facility document, titled, Clinical Care Plan Detail, no date, showed: .Focus: Resident #2 is High risk for falls r/t confusion, Gait/balance problems, Unaware of safety needs, arthritis, heart failure, edema, depression .Goals: Resident #2 will not sustain serious injury through the review date .Interventions/tasks: Fall matt to floor . [sic] Review of the facility's policy titled, Fall Risk Assessment/Prevention, CCS114, Copyright 2025 [NAME] Health [NAME], showed: . For residents at increased risk, additional safety measures individualized to the resident and situation will be identified on the plan of care and implemented by the interdisciplinary team .