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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 47752 Based on observation, interview, and record review, the facility failed to have a process in place to identify and assess residents for self-administration of medications for 2 (#s 4 and 15) of 14 sampled residents. Findings include: During an observation and interview on 5/5/25 at 1:50 p.m., staff member C knocked on the door and entered resident #4's room. Staff member C administered resident #4 her oral medications and mixed her MiraLAX in some apple juice. Staff member C stated, I leave the juice with the MiraLAX on the bedside table for resident #4. Staff member C could not verbalize if resident #4 was able to self-administer her own medications. During an observation and interview on 5/6/25 at 8:46 a.m., staff member F walked into the medication room and began to set up resident #15's medications. Staff member F completed setting up resident #15's medications and walked to his room. Staff member F knocked on the door and handed resident #15 his medications. Resident #15 placed the medication cup on the bedside table and stated, I will take them in a bit. Staff member F stated, OK, I will come back and check on you in a little bit. Staff member F left the room. Review of resident #4's electronic medical record dated 3/1/25 to 5/7/25 showed no physicians order for self-administration of medications, and no assessment for self-administration of medications. Review of resident #15's electronic medical record dated 3/1/25 to 5/7/25 showed no physicians order for self-administration of medications, and no assessment for self-administration of medications. During an interview on 5/6/25 at 10:25 a.m., staff member A stated, There are no assessments for self-administration of medications for resident #s 4 and 15. Staff member A stated, None of the residents are supposed to be self-administering their medications. A review of a facility document titled, Self-Administered Medications (Bedside Medications), PHA127, with an effective date of 2/2024, showed: . Procedure (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If the prescriber wants the patient to self-administer a medication, there must be a valid order for the medication . The order shall specify the drug, dose, route, directions for use, and the quantity .Per State Regulations, medications must be secured at all times. Therefore, patients will not be allowed to keep medications at bedside without a specific provider order.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752 Based on interview and record review, the facility failed to ensure a baseline care plan was completed within 48 hours to include the minimum health care information necessary to properly care for 1 (#19) of 14 sampled residents. Findings include: Review of resident #19's electronic medical records, dated 3/28/25 to 4/5/25, showed resident #19 was admitted to the facility on [DATE] with the diagnoses of hypertension, history of falls, confusion, osteoarthritis, frequent urinary tract infections and back pain. Review of resident #19's physician admission note, dated 3/31/25 showed, resident #19 had an indwelling Foley catheter, and used oxygen. Review of resident #19's baseline care plan showed two complete entries. One for pain and one for ineffective peripheral tissue perfusion. The base line care plan showed no focus, goals, or interventions, for Foley catheter use, ADL status, transfer status, cognitive status, fall status, or oxygen use. During an interview on 5/6/25 at 4:16 p.m., staff member F stated she was responsible for base line care plans. Staff member F stated base line care plans need to be completed within 48 hours of a patient's admission. Staff member F stated, I should have put more information on the care plan. During an interview on 5/7/25 at 9:10 a.m., staff member B stated her expectation for baseline care plans was they are to be completed within 48 hours of admission. Staff member B stated the base line care plan needed to have all the information needed for the resident to be cared for by staff. Review of a facility document titled, Care Planning Process, CCS106, dated 2/2023, showed: . 4. Care plans are individualized to address the resident's problems, needs, severity of condition, impairment, disability, or disease. The care plan addresses needs and care priorities . [sic]

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52362 Based on observations, interviews, and record review the facility failed to ensure a resident's comprehensive care plan was evaluated for effectiveness or revised as needed for 3 (#s 2, 4, and 16) of 14 sampled residents. Findings include: 1. During an interview on 5/5/25 at 7:34 p.m., staff member E stated everyone should know how to tell if a resident was a fall risk by looking at the care plans and from information shared during staff meetings. Staff member E stated she could make immediate interventions to prevent falls on the night shift until an investigation was done, By telling my CNAs during a little group meeting with them; I communicate with them a lot. Staff member E stated there were no new immediate interventions put in place after resident #2 fell on [DATE] and had to be sent to the ER with a major injury. During an interview on 5/06/25 at 11:06 a.m., staff member B stated resident #2 had fall interventions in place and they were being implemented. Staff member B stated, We let CNAs know the fall interventions; they can also look at the care plan or kardex to see any new interventions; nurses can look at them too. Staff member B stated, Staff member F updates care plans right after incidents or after care plan meetings every Wednesday. During an interview on 5/06/25 at 11:21 a.m., staff member F stated, Nurses and CNAs know the fall interventions, they can see the care plan and kardex, I make sure they know. Review of a facility document titled, Care Planning Process, CCS106, dated 2/2023, showed: .Procedure . 19. The care plan is reviewed and/or revised at 90 day intervals or more frequently .Care plan revisions must reflect the resident's current needs, problems, goals, care and services needed . [sic] Review of a facility document, titled, Care Plan History, created 12/2/2019, showed: .Changes Prior to Completion of Last Review, Description: Resident #2 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 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 . 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.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] 47752 2. 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 struggled with depression and anxiety but was currently well controlled, and she was no longer taking medication for the anxiety. A review of resident #4's care plan, with a revision date of 3/11/25, showed a pathological fracture of the right hip. The care plan was not revised to show resident #4 had a pathological fracture of the left hip. A review of resident #4's physician orders, dated 1/2019, showed clonazepam (anti-anxiety) had been discontinued on 1/8/19. Review of resident #4's care plan dated 2/26/25, showed resident #4 was still taking an anti-anxiety medication. During an interview on 5/6/25 at 4:16 p.m., staff member F stated, Yup, I probably overlooked it. The care plan should have been revised when the medication was discontinued. Staff member F stated she was responsible for revising the care plans. Staff member F stated care plans were to be revised with the quarterly or annual assessment, and if any changes occurred with the residents. During an interview on 5/7/25 at 9:10 a.m., staff member B stated it was her expectation for care plans to be revised quarterly, annually, with any significant change, and when there were any new medications or changes with a resident. During an interview on 5/7/25 at 12:13 p.m., staff member F stated resident #4 was taking clonazepam at one time but was changed to Vistaril for anxiety and she should have taken it off the care plan when it was discontinued on 12/4/24. Review of resident #4's physician orders, dated 12/4/24, showed: Vistaril Oral Capsule, Give 25 mg by mouth every 24 hours as needed for itching. Discontinue 12/4/24. [sic] 32998 3. During an interview on 5/7/25 at 12:13 p.m., staff member F stated the care plan goals and interventions should be updated when the resident's needs and status changed. During an interview on 5/7/25 at 1:27 p.m., staff member H stated the resident was supposed to be repositioned every two hours and only up in chair during meals. Staff member H stated any changes to the care plan were found on the communication board or we get the information during shift change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/25 at 2:32 p.m., staff member B stated interventions on the care plan should include turning and repositioning, lay down after meals, float heels, and keep him off his bottom. Staff member B stated the resident had an infection in his pressure ulcer, and it was treated with an antibiotic. Review of resident #16's care plan, with an initiated date of 11/29/24, showed the resident had goals and interventions for an infection. Review of the resident's EHR showed the infection was treated effectively. Review of the resident's care plan, with an initiated date of 3/18/25, showed goals and interventions for a Stage II pressure ulcer. Review of the resident's care plan showed goals and interventions for a Stage III pressure ulcer, with an initiated date of 12/2/24. Resident #16's care plan failed to show updated treatments and interventions for the resident's pressure ulcers.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47752 Based on observation, interview, and record review, the facility staff failed to follow facility policy and professional standards of practice for medication administration involving pre-pouring of medications. Findings include: During an observation and interview on 5/6/25 at 7:50 a.m., staff member F was standing at the medication cart located at the entrance to the dining room. Staff member F opened the top drawer of the medication cart and inside were 8 plastic medication cups full of medications. Staff member F stated per the policy she was allowed to pre-pour medications as long as they are given within the hour. A request was made for a pre-pour medication policy on 5/6/25 at 9:03 a.m., and was not received prior to the end of the survey. During an interview on 5/6/25 at 10:22 a.m., staff member A stated, We do not have a policy allowing staff to pre-pour medications, we do not allow that in this facility. During an interview on 5/6/25 at 11:16 a.m., staff member F stated, I was in the wrong this morning, and I know that I am not supposed to pre-pour medications. I have been a nurse for a long time, and I know better. I know I should not have done that. During an interview on 5/7/25 at 7:35 a.m., staff member L stated, We are not allowed to pre-pour any medications, this is for patient safety. Review of a facility document titled, Medication Administration, CCS123, dated 2/2023, showed: . Procedure: . II. Medication Administration: The nurse will prepare and administer one residents medications at a time. [sic]

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32998 Based on observation, interview, and record review, the facility failed to provide services for pressure ulcer care to prevent worsening of a pressure ulcer for 1 (#16) of 14 sampled residents. Resident #16 was admitted with Stage II pressure ulcers to his right buttock, right hip, and left buttock. The Stage II pressure ulcer to his right buttock worsened to a Stage III. Findings include: During an interview on 5/7/25 at 1:27 p.m., staff member H stated resident #16 was to be repositioned every two hours, lie down after each meal, and get up for meals. Staff member H stated the resident was usually tired after wound care but does not usually express pain after wound care. During an observation and interview on 05/07/25 at 1:44 p.m., of wound care for resident #16 by staff members L and J, staff member L stated staff member F measured the wound(s) on Tuesdays. Staff member L stated she did not measure the wounds. Staff member L stated the right buttock gets better and then would get worse again. Staff member L stated the resident was not getting enough protein, so he was now at a table where he received assistance to eat. Staff member L stated the resident was eating more than he was when he was independently feeding himself. The resident's wound was irrigated with wound cleanser, dried with gauze, applied gel pads and collagen times four for packing with finger, one pad to the top of the wound, and covered with mediplex. Staff member L stated the tunneling, in the wound, appeared to be not as deep. Staff member L stated the wound bed looked better than the last time she had seen it. Staff member L stated wound debridement was done when the resident went to the clinic. Staff member L stated the provider had not implemented a wound vac. During an interview on 5/7/25 at 2:32 p.m., staff member B stated resident #16 had not gotten any new wounds since admission. Staff member B stated the staff were to turn and reposition the resident every two hours and lay down after meals. Staff member B stated the resident was taking prostat for wound healing, but had not liked it, so his Glucerna was increased. Staff member B stated the resident sees the provider for wound care. Staff member B stated the resident had four wounds when he was admitted . Staff member B stated the staff were to keep the resident off his bottom as much as possible. Staff member B stated when they had sent other residents to the wound clinic and the only dressings they recommended was wet to dry. Staff member B stated they had never considered a wound vac because the provider felt the area wouldn't keep a good seal. Staff member B stated the product being used for the residents' wound is what causes so much drainage. Staff member B stated resident #16's wound had gotten infected and was treated with an antibiotic. During an interview on 5/7/25 at 3:23 p.m., staff members A, B, and F stated the provider made the wound deeper when he debrided it. Staff member F stated the provider had performed debridement at least three times. Staff member F stated there were weekly notes showing the debridement. These notes were requested and were not provided for review. Review of resident #16's EHR showed there were no skin assessments documented from 11/26/24 through 1/13/25. A request for the skin assessments was made on 5/6/25 for any skin assessments from admit to current. There were skin assessments missing for 11/26/24 through 1/13/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #16's Skin Assessment on admission, dated 11/25/24, showed three pressure ulcers. All three pressure ulcers were documented at Stage II. Review of the resident's Skin Assessment, dated 1/14/25, showed one pressure ulcer documented at a Stage III. Review of resident #16's Progress Notes, dated 11/25/24 through 12/2/24, showed the resident had dressing changes to three Stage II pressure ulcers. Review of resident #16's Care Plan for pressure ulcers, with an initiated date of 3/18/25, showed the resident had a Stage II pressure ulcer to his coccyx. Review of resident #16's Care Plan for infection, with an initiated date of 11/29/24, showed the resident had goals and interventions for infection of a Stage III pressure ulcer to the right buttock. The care plan failed to show updated information regarding consistent staging of the wounds and and current treatment. Review of the facility policy, titled Wound Management, showed: - Under Procedures . 1) Assess the wound . 2) Make a progress note . 3) place order in MAR . 4) implement nutritional interventions . 5) Place order in TAR under other for Weekly wound assessment . Under Documentation . a. Weekly Pressure Ulcer Healing Record: This is full assessment of the area, size, full description of the wound and surrounding tissue, response to treatment, which will be done until healed . 3. IDT will record the wound and the ordered treatment on the Wound Care Log . 4. The care plan will be updated with interventions and treatments . 5. a. Every seven days from the initial discovery of the wound, a full wound assessment will be completed and documented on the Treatment Sheet . Progress notes will be completed for all dressing changes, changes in the wound, changes in treatment, and the time when the wound is determined to be healed. [sic]

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47752 Based on observation, interview, and record review, the facility failed to ensure safe labeling of food storage in accordance with professional standards for food service safety, placing all residents at risk for consumption of expired or contaminated food and for food-borne illness; failed to develop and implement policy and procedures regarding food storage and labeling; and failed to label and date resident food or drink located in a refrigerator in the medication room for 2 (#s 4 and 15) of 14 sampled residents. These deficient practices affected all residents receiving food services from the facility. Findings include: 1. During an observation on [DATE] at 11:32 a.m., the following had incomplete, missing, or expired food dates in the kitchen: - Equal sweetener (opened), no facility dates marked on container, expiration date on container was , d+[DATE]; - Ground Cloves (opened), dated [DATE] - [DATE]; - Sour Cream (opened), dated [DATE], no use by date; - Mozzarella cheese (opened), dated best by [DATE]; - Liquid whole eggs (opened), no dates on container. During observations and interviews on [DATE] at 8:20 a.m., an opened milk container with a received date of ,d+[DATE], and an opened date of ,d+[DATE] was in the refrigerator. Staff member I stated the use by date for dairy is one day after opening. Staff member K stated it needed to be thrown out, I'm sorry. Staff member K stated she did not have a procedure for checking expiration dates but needed one. 2. During an observation and interview on [DATE] at 1:18 p.m., staff member C opened the medication storage room. In the corner was a small refrigerator which stored items for residents. The refrigerator had one can of beer on the bottom shelf. No patient identifiers were noted on the can. One bottle of International Delight Carmel Macchiato coffee cream was located on the door shelf. The bottle was opened. No resident identifiers or open date was noted on the bottle of creamer. One bottle of unopened Coffee Mate zero sugar hazelnut creamer was located next to the other creamer. No patient identifier was noted on the bottle. A large box located in the medication room positioned close to the refrigerator had a large amount of unopened beer cans inside. No resident identifier was present on the cans or the box. Staff member C stated they used the coffee creamer for resident #4 most of the time, and the beer belonged to resident #15. Staff member C stated, You would not know who this stuff belonged to unless you work here, a new staff member or traveler would not know who it belonged to. A request was made on [DATE] at 9:06 a.m., for a food storage policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:22 a.m., staff member A stated they do not have a policy of food storage. 52362