STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275065	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Nursing Home of Anaconda	615 Main St Anaconda, MT 59711

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation and interview, the facility failed to have a designated registered nurse to serve as the director of nursing on a full-time basis. This deficient practice resulted in a failure of clinical oversight for all residents residing in the facility. Findings include: During an observation on 12/15/25 at 9:00 a.m., the Director of Nursing was not present at the facility. During an interview on 12/15/25 at 9:15 a.m., staff member A stated the Director of Nursing resigned on 12/2/25, and a new Director of Nursing would start on 12/29/25. Staff member A stated she did not assign an interim Director of Nursing because she knew the new Director of Nursing would be starting soon. Review of a facility provided document, Survey Information, dated 8/18/25, reflected that the Director of Nursing resigned on 12/2/25, and a new Director of Nursing would start on 12/29/25. Review of a facility policy, Nursing Services, with a revision date of 10/2022, reflected: - . 3. b. Except when waived the facility must designate a registered nurse to serve as the director of nursing on a full-time basis. Review of an email communication, sent to the State Survey Agency, dated 12/4/25, related to the Director of Nursing Hourly Requirements, showed staff member A requested clarification on the regulatory requirement for the DON hours and coverage of the position duties. The communication showed staff member A was aware of the DON designation requirement(s) prior to the survey.

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to submit mandatory payroll-based data to CMS. This deficient practice prevented CMS review of the level of staff, employee turnover, and tenure to ensure safe staffing levels. Findings include:Review of the PBJ Staffing Data Report, dated 12/9/25, for quarter four (7/1/25-9/30/25) reflected the facility failed to submit data for the quarter. During an interview on 12/15/25 at 9:15 a.m., staff member A stated the facility did not submit the PBJ for the fourth quarter of 2025 and once the facility realized the data had not been submitted, it was too late to submit the data.

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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 interviews and record review, the facility failed to ensure the QAPI team identified, reported, investigated, and documented the development, implementation, and evaluation of corrective actions for performance improvement projects related to known activities department deficient practices for 2 (#s 2 and 6) of 14 sampled residents, and this failure increased the risk of all residents being affected due to the lack of necessary or preferred activities. Findings include:During the survey from 12/15/25-12/17/25, the facility failed to provide activities to meet the interests and preferences of residents who remained in their rooms for resident #s 2 and 6. (See F0679)During an interview on 12/16/25 at 9:50 a.m., staff member A stated there had been a struggle to get activities to take charge and work the activities programs. Staff member A stated she was aware the one-to-one visits and activities the activities staff should be doing were not being done. During an interview on 12/17/25 at 11:07 a.m., staff member A stated she interviewed staff after surveyors questioned the one-to-one visits and had found the activities staff were falsifying documentation on one-to-one visits, documenting the residents refused, were sleeping, or the staff were kicked out of the room when they had not attempted to complete the required one-to-one visit. Staff member A stated she had not been auditing the activities department's completion of one-to-one visits. Staff member A stated the facility only did one performance improvement plan per year, and the QAPI team chose to work on ambulation-based data review. Staff member A stated that no other performance improvement activities were completed since the previous survey. Staff member A stated the QAPI team had not considered a performance improvement plan for the activity department concerns, even though she was aware of the deficient practices in the activity department.Review of the facility's Quarterly QAPI minutes, dated 1/2020 - 10/2025, reflected no information for the activity department concerns, the lack of provision of activities, falsification of documentation, or concerns related to the well-being of residents who were not receiving activities. The facility QAPI committee failed to identify, address, and or attempt to correct the quality deficient practices for the activity department and staff involved, which affected all residents. Review of the facility policy, QAPI Program/Plan, Disclosure/Good Faith Attempt, dated 10/22, reflected:- Quality Assurance and Performance Improvement (QAPI) is a data driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure the required personal protective equipment, i.e. N95 respirator, was available to staff and visitors. upon entry to the facility during a COVID-19 outbreak; failed to ensure staff properly wore N95 respirators during a COVID-19 outbreak; and failed to ensure staff wore faceshield/masks while in residents' rooms who had tested positive for COVID-19 for 4 (#s 6, 9, 12, and 16) of 4 confirmed COVID-19 positive residents, which remained on contact and droplet precautions. These failures likely contributed to the spread of COVID-19 and could affect all residents, staff, or visitors at the facility. Findings include:1. Entrance Personal Protective Equipment During an observation when entering the facility on 12/15/25 at 9:00 a.m., a sign was posted on the outside window beside the entrance door, which showed the facility was in outbreak status for COVID-19. Inside the entrance door was a small vestibule, which had a desk with a notebook to sign in as a visitor and screening for signs and symptoms of COVID-19, including a thermometer to screen for an increased body temperature. On the door to enter the facility, a sign was posted with a picture of a paper mask required to enter the facility, and handwritten on the sign was N95. Also in the vestibule, there was a stand which had paper masks available for visitors, but no N95 masks were available to wear. During an observation on 12/15/25 at 4:01 p.m., staff member A's elementary aged son arrived at the facility and walked through the building to staff member A's office without an isolation mask on, as to protect himself, residents, or staff. Staff member A was in her office without a mask on, with the door open. During an observation and interview on 12/17/25 at 9:30 a.m., NF2 was in resident #6's room with a paper mask on doing a blood draw on resident #6. Resident #6 was on EBP and airborne precautions for active COVID-19. NF2 stated she did not see the signage on the door because it was too small, and the sign on the front entry only showed a picture of a paper mask. NF2 stated she did not see the small print above the picture that showed N95, and only paper masks were provided at the entry. NF2 stated she called ahead, and no one mentioned N95 masks or COVID-19 restrictions for resident #6. The facility failed to provide or make available N95 masks upon entrance into the facility when there were confirmed cases of COVID-19. Review of the facility's procedure titled, COVID-19 Outbreak, last revised 7/28/22, showed: - . 5. Visitors must be screened for Covid s/s before entering the building. If cleared to come in they need to wear a mask, wash hands upon arrival and before leaving - All staff need to provide the education and reminders, and - 6. Ensure face masks are available at the front door. [sic] 2. Properly Worn N95 Masks During an observation on 12/16/25 at 9:50 a.m., staff member A was in her office, with the door open, talking to another staff member with no isolation mask on. During an observation on 12/17/25 at 7:26 a.m., staff member B was preparing medications at the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medication cart, wearing an N95 mask. Staff member B had not secured the top strap of the mask and was holding the mask on her face with her hand. During an observation on 12/17/25 at 7:26 a.m., staff member H was standing in a resident's doorway, wearing an N95 mask with the top of the mask resting below his nose. During an observation on 12/17/25 at 7:39 a.m., staff member C was wearing an N95 mask without the upper strap of the respirator over her head. The top strap was hanging on the front of her mask, over her nose, not creating a proper mask seal. During an observation on 12/17/25 at 7:40 a.m., staff member B was standing at the medication cart, wearing an N95 mask, with the mask top strap hanging in front of her face. During an observation on 12/17/25 at 7:44 a.m., staff member H was wearing an N95 mask, the mask was sitting below his nose. During an interview on 12/17/25 at 7:47 a.m., staff member H stated he recently had training on the proper use of N95 masks. Staff member H stated he could not breathe with the top strap of the N95 mask over his head, as required. Staff member H stated he would wear the mask with the top strap down until he was around a resident. During an observation on 12/17/25 at 9:23 a.m., staff member E was in the activities room with her mask pulled down, with a resident within inches of her face, and she was talking loudly, asking if she wanted a donut. During an interview on 12/17/25 at 9:38 a.m., staff member A stated N95 masks should be worn properly to be effective. Review of the CDC referenced instruction sheet titled, Sequence For Putting On Personal Protective Equipment (PPE), undated, showed: - . 2. Mask or Respirator, - Secure ties or elastic bands at middle of head and neck, - Fit flexible band to nose bridge, - Fit snug to face and below chin, and - Fit-check respirator. 3. Face Shields/Goggles Review of an infection control spreadsheet listing, dated 12/16/25, of the last four residents who tested positive for COVID-19 showed: - Residents #6 and #12 were confirmed positive on 12/9/25, - Resident #9 was confirmed positive on 12/11/25, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Resident #16 was confirmed positive on 12/16/25. This listing showed the COVID-19 virus continued to spread to other residents. During an observation on 12/16/25 at 8:02 a.m., staff member B was passing medications to resident #12 in his room. Resident #12 had tested positive for COVID-19 on 12/9/25. Staff member B was not wearing a face shield or protective eyewear. During an observation on 12/17/25 at 7:40 a.m., staff member B was passing medications to resident #9 in her room. Resident #9 had tested positive for COVID-19 on 12/11/25. Staff member B was not wearing a face shield or protective eyewear. During an observation on 12/17/25 at 8:13 a.m., a droplet precautions sign was posted on the door frame of resident #9's and #12's room. The signage showed a gown and gloves were to be worn for entry, and Mask/face shield is indicated for those who come within 3 feet of patient/resident. During an observation on 12/17/25 at 8:14 a.m., staff member C was assisting resident #9 with her morning meal. Staff member C was not wearing any form of face shield or goggles. During an observation on 12/17/25 at 8:15 a.m., none of the PPE carts located outside or directly inside the rooms of residents #6, #9, #12, and #16 had any form of face shield or goggles in the carts. During an interview on 12/17/25 at 9:38 a.m., staff member A stated all staff were to wear protective eyewear/face shields when entering into a COVID-19 positive resident's room with contact and droplet precautions posted. Staff member A stated the staff had PPE available to them, and staff knew they were to wear the proper PPE during a COVID-19 outbreak. Review of the facility's procedure titled, COVID-19 Outbreak, last revised 7/28/22, showed: - . Staff adhere to strict PPE (Personal Protective Equipment) use, including: N95 mask, protective eyewear such as goggles or facemask, gown, gloves and continue to perform proper hand hygiene when performing direct care. All staff use N95 masks and protective eyewear to limit exposure risk. Contact isolation precautions include contact, airborne and droplet when working with Covid-19 residents. [sic] Review of the State of Montana Epidemiology and Scientific Support Bureau outbreak tracking, provided to the State Survey Agency, and dated for 12/12/25 and 12/18/25, showed the COVID-19 outbreak began at the facility on 12/2/25. As of 12/18/25, there were a total of 11 cases: three residents and eight staff. When surveyors were onsite at the facility, there were four resident cases identified, as resident #16 was confirmed positive for COVID-19 during the survey, which reflected the facility staff were not proactively or successfully preventing the spread of COVID-19.

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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 observation and interview, the facility failed to ensure medication error rates were not 5 percent or greater by crushing medications administered to residents without a physician's order for 2 (#s 7 and 13) of 5 residents observed for medication administration. The medication error rate was 24 percent. Findings include:During a medication administration observation on 12/16/25 at 8:21 a.m., staff member B prepared resident #7's medications. The following medications were placed into a plastic medication cup, crushed, then added to applesauce:- citalopram hydrobromide 20 milligram tablet, give one tablet,- acetaminophen 500 milligram tablet, give two tablets, and- sennosides-docusate sodium 8.6-50 milligram tablet, give two tablets.Staff member B administered the crushed medications to resident #7. These medications were administered without a physician's order for crushed medications.During a medication administration observation on 12/16/25 at 8:38 a.m., staff member B prepared resident #13's medications. The following medications were placed into a plastic medication cup, crushed, then added to applesauce: - cholecalciferol 1,000 unit tablet, give two tablets,- oxybutynin chloride 5 milligram tablet, give 0.5 tablet,- sennosides-docusate sodium 8.6-50 milligram tablet, give one tablet, and- trazodone hydrochloride 50 milligram tablet, give 0.5 tablet.Staff member B administered the crushed medications to resident #13. These medications were administered crushed without a physician's order for crushed medications.During an interview on 12/16/25 at 12:28 p.m., staff member B stated there were not orders for crushed medications for residents #7 and #13. Staff member B stated she knew which residents' medications to crush from the facility's roster/shift change sheet for nurses.During an interview on 12/16/25 at 12:35 p.m., staff member A stated there were no physician's orders for crushed medication for any of the facility's residents. During an interview on 12/16/25 at 1:15 p.m., staff member D stated she knew some residents were receiving crushed medications but did not know those medications were being administered without a physician's orders for crushed medications.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record review, the facility failed to ensure catheter bags were covered for 1 (#6) of 14 sampled residents. This deficient practice resulted in resident #6 feeling embarrassed to have the catheter bag visible to others. Findings include:During an observation and interview on 12/15/25 at 10:40 a.m., resident #6 was in his recliner in his room with the door open. Resident #6 had a catheter bag hanging from the pocket of his recliner filled half full of dark yellow urine. The catheter bag was facing the door and visible to those who walked past his room. Resident #6 stated, It's whatever, when the catheter bag and dignity was discussed. During an observation and interview on 12/16/25 at 9:10 a.m., resident #6's catheter bag was hanging from his right pocket of his recliner, uncovered, and was 1/4 filled with urine. The catheter bag was facing the doorway, and the door was open to the hallway. Resident #6 stated, It's a bit embarrassing, when asked about the catheter bag. During an interview on 12/16/25 at 11:40 a.m., staff member J stated the facility had two catheter bag covers available in the supply closet, and they should be on the catheter bags of residents who used catheters. Staff member J went to staff member A's office and requested that she order more catheter bag covers. During an interview on 12/16/25 at 11:47 a.m., staff member K stated the catheter cover will rip and fall off, but he would go put a catheter cover on resident #6's catheter bag. Review of resident #6's care plan, with a revision date of 10/15/25, reflected resident #6's catheter was to be positioned below the level of the bladder and facing away from the entrance of the room door. During an interview on 12/16/25 at 2:08 p.m., staff member A stated the facility did not have a policy and procedure for covering catheter bags to ensure a resident's dignity is maintained.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review, the facility failed to honor a resident's preferences of not being woken up in the morning and given a breakfast tray for 1 (#2) of 14 sampled residents. This deficient practice caused resident #2 frustration and anger leading to behaviors. Findings include:During an observation and interview on 12/15/25 at 10:45 a.m., resident #2 stated she was angry the staff continued to wake her and bring in a breakfast tray every morning even though she repeatedly asked them not to bring in a breakfast tray. Resident #2 stated she had never eaten breakfast and was not going to start. Resident #2 stated it was frustrating the facility would not listen to her wishes. The breakfast tray was sitting on her bedside table uneaten. During an interview on 12/15/25 at 11:45 a.m., staff member J stated resident #2 had not eaten breakfast since she was admitted to the facility. Staff member J stated she was told by the kitchen that resident #2 must receive a tray even if she refuses it. Staff member J stated that resident #2 would become very angry and had a history of throwing her trays at staff. Staff member J stated the resident was not offered breakfast at a later time but was offered a snack before lunch. Review of resident #2's care plan, with a revision date of 11/19/25, reflected resident #2 had a personal history of refusing breakfast.Review of a nurse's progress note, dated 12/16/25 at 9:08 a.m., reflected, Res. was offered her tray twice this a.m. and refused twice. She was offered when it was brought in and later after the CNA fed someone else she came back to resident's room and offered again to help her eat and res. refused again. [sic]During an interview on 12/17/25 at 9:50 a.m., staff member A stated she did not know where the rule came from, but the staff were told to bring her a tray each morning regardless of whether the resident wanted one or not. Staff member A stated she often became very agitated and would hit, throw things, and cursed at the staff. Staff member A stated she did not have a policy showing meal trays must be given regardless of residents' preferences. Staff member A stated she did not have documentation of any resident education offerinng resident #2 an altered meal schedule and she continued to refuse.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure staff member B protected a resident's right to privacy and confidentiality of her medical record for 1 (#9) of 5 residents observed for medication administration. Findings include:During an observation on 12/17/25 at 7:43 a.m., staff member B was in resident #9's room, administering her medications. The medication cart was parked outside resident #9's room. The computer used for medication administration was on top of the medication cart, with the computer screen open to resident #9's medication listing with her picture visible. At the time of the observation, another resident had exited her room and passed directly next to the medication cart.During an interview on 12/17/25 at 10:54 a.m., staff member B stated the computer on the medication cart should be locked each time she (staff member B) stepped away from the cart so a resident's record could not be seen by others.Review of the facility's policy titled, Confidentiality of Information, undated, showed:-.Confidentiality of the patient record shall be maintained at all times by keeping the record closed when not in use. If an electronic health record is used, ensure that no other individual can read the screen and log-off the computer when not in use.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews and record review, the facility failed to develop a comprehensive person-centered care plan, including the residents' preferences, for 2 (#s 2 and 6) of 14 sampled residents. This deficient practice resulted in resident #s 2 and 6 not having activities to meet their preferences. Findings include: 1. During an observation and interview on 12/15/25 at 10:45 a.m., resident #2 stated she did not get out of bed anymore and did not have activities available in her room. She discussed her activities of interest, to include reading and quilting, but these things were not offered to her.Review of resident #2's care plan, dated 11/10/25, reflected resident #2 had little or no interest in activities. The care plan reflected, . [Resident name] enjoys watching television in her room, visiting in her room with friends and family, and going on outings with her family as able. The care plan did not include information related to the interest's resident #2 relayed during the interview. Review of resident #2's Kardex, dated 12/16/25, reflected a variety of activities, such as 1:1 activity, arts and crafts, ball toss/beanbag toss, barber, bingo and others. These activities were not noted on the resident's comprehensive care plan. Review of resident #2's activity assessment, date 11/12/25, reflected that resident #2's preferences included pets, tv/movies, and youth visits. Although the activity assessment identified activities she was interested in, these were not reflected in her comprehensive care plan.2. During an observation and interview on 12/15/25 at 10:40 a.m., resident #6 was in his recliner resting with the television on, and stated he did not come out of his room and did not have any visits from the activity staff, except for them to drop off a schedule of group activities. Resident #6 stated he was not receiving his newspaper in the mornings either. Review of resident #6's comprehensive care plan, dated 10/15/25, reflected, . Provide peasant diversional activities such as conversation, newspapers, TV and structured group activities to decrease exit seeking behavior and promote safety. [Resident #6] enjoys reading the paper with coffee and watching the news. [sic]During an interview on 12/16/25 at 9:17 a.m., with staff members J, K, and L, staff members J, K, and L stated they were not aware that resident #6's care plan showed he enjoyed the newspaper with coffee, and the facility did not always receive a newspaper. Staff members J and K stated that the CNAs could not see the resident's care plan, which should show identified activities of interest. Staff member J stated the Kardex and care plan did not reflect resident #6's preferences, as he did not want to leave his chair, and many of those activities listed, he had never done. Staff member J stated resident #2 did not get out of bed anymore, so her Kardex and comprehensive care plan also did not reflect her current status for activities. During an interview on 12/16/25 at 9:50 a.m., staff member A stated there was no activity care plan for resident #6.During an interview on 12/16/25 at 8:45 a.m., staff member E stated she did not use the care plan and did not enter anything for resident activities on the care plan. Staff member E stated that staff member A must be creating the activities care plan, but the activities department did not use that care plan. Staff member E stated the activities department used the activities assessments, which were done quarterly, to determine the residents' activity needs. During an interview on 12/16/25 at 9:50 a.m., staff member A stated she added all the activities to every Kardex, regardless of resident preferences, and stated the CNAs use the Kardex as the resident care plan.During an interview on 12/16/25 at 10:02 a.m., staff member E stated she could see there was a disconnect between the resident care plans staff member A created, the Kardex used by CNAs, and the assessments used by the activities department.Review of the facility policy, Resident Centered Care Plan, dated 10/2022, reflected:- . Each resident will have a person-centered comprehensive care plan developed and implemented to meet his preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275065	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Nursing Home of Anaconda	615 Main St Anaconda, MT 59711

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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. Based on observation, interview, and record review, the facility failed to ensure staff member B adhered to medication administration best practice by crushing a medication indicated on a Do Not Crush medication listing for 1 (#13) of 5 residents observed for medication administration. Findings include:During a medication administration observation on 12/16/25 at 8:38 a.m., staff member B prepared resident #13's medications. The following medications were placed into a plastic medication cup, crushed, then added to applesauce:- cholecalciferol 1,000 unit tablet, give two tablets,- oxybutynin chloride 5 milligram tablet, give 0.5 tablet,- sennosides-docusate sodium 8.6-50 milligram tablet, give one tablet, and- trazodone hydrochloride 50 milligram tablet, give 0.5 tablet.Staff member B administered the crushed medications to resident #13.During an interview on 12/16/25 at 12:28 p.m., staff member B stated she knew which residents' medications to crush from the facility's roster/shift change sheet for nurses. Staff member B stated there were not any labels on any resident's medication bubble packets which indicated medication was not to be crushed. Staff member B stated she knew not to crush an extended-release medication but otherwise she would not know which medications should not be crushed.During an interview on 12/16/25 at 12:32 p.m., staff member B stated she was unaware trazodone for resident #13 was listed on a DO NOT CRUSH listing of medications.During an interview on 12/16/25 at 12:35 p.m., staff member A stated she did not know trazodone was an indicated DO NOT CRUSH medication.During an interview on 12/16/25 at 1:15 p.m., staff member D stated trazodone was on the DO NOT CRUSH medication listing.During an interview on 12/16/25 at 2:08 p.m., staff member A stated the facility did not have a policy/procedure for crushed medications.Review of a document titled, PharMerica Oral Medications That Should Not Be Crushed or Altered, dated 2/2023, showed trazodone as a medication which should not be crushed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, interviews and record review, the facility failed to provide activities to meet the interests and preferences of residents who remain in their rooms for 2 (#s 2 and 6) of 14 sampled residents. This deficient practice led to boredom for resident #6 and frustration for resident #2. Findings include:1. During an observation and interview on 12/15/25 at 10:45 a.m., resident #2 stated, I'm just laying here playing dead I guess. Resident #2 stated she did not get out of bed anymore and did not have activities in her room. Resident #2 stated she used to quilt and read. Resident #2 stated she liked to read modern romance and adventure books, but they were not offered to her. Resident #2 stated, I guess they just leaving me to play dead.Review of resident #2's care plan, dated 11/10/25, reflected resident #2 had little or no interest in activities. The care plan reflected, . [resident #2] enjoys watching television in her room, visiting in her room with friends and family and going on outings with her family as able.Review of resident #2's Kardex, dated 12/16/25, reflected activities to include donuts and news, one-to-one activity, arts and crafts, ball toss/beanbag toss, barber, bingo, cooking, educational presentations, exercise, family involvement, gardening, holiday party, jazzercise, manicures, morning stretches, movie, music event, out of facility, parade, pet therapy, picnic, television in her room, reflections, religious services, reminiscing basket, resident council, self-directed activity, social hour, van ride, visitors, walking outside, wheelchair yoga, women's luncheon, youth visitors and games.Review of resident #2's activity assessment, date 11/12/25 reflected resident #2's preferences included pets, TV/movies, and youth visits.2. During an observation and interview on 12/15/25 at 10:40 a.m., resident #6 was in his recliner resting with the television on. Resident #6 stated, I really don't do much but sleep in this chair. I'm not tired really but watch TV and sleep. No activities, not really sure about what they have for me. Resident #6 stated he did not come out of his room and did not have any visits from the activities department except to drop off a schedule of group stuff and sometimes coloring stuff. Resident #6 stated he was not getting his newspaper in the mornings anymore. Resident #6 stated he did not know why he was not receiving the newspapers.Review of resident #6's care plan, dated 10/15/25, reflected, . Provide peasant diversional activities such as conversation, newspapers, TV and structured group activities to decrease exit seeking behavior and promote safety. [Resident #6] enjoys reading the paper with coffee and watching the news. [sic]During an interview on 12/16/25 at 9:17 a.m., with staff members J, K, and L, staff members J and K stated the facility did not receive the newspaper for a long time except the [newspaper name] a couple of times a month. Staff members J, K, and L stated they were not aware resident #6's care plan showed he enjoyed the newspaper with coffee. Staff member J and K stated the CNAs only had access to the Kardex. Staff member K stated resident #6 did not leave his recliner and did not participate in group activities. Staff member J stated resident #6 told her he hated Bingo and did not participate in Bingo. Staff member J stated the Kardex, and the care plan did not reflect resident #6's activity preferences since he did not want to leave his chair for the last few months. Staff member J stated resident #2 did not get out of bed anymore so her Kardex and care plan also did not reflect her current status for activities. Staff members J, K, and L stated activities were not done for residents who did not leave their rooms. Staff member K stated they had not seen any one-to-one activity visits completed in the facility in a long time, at least months if not longer.Review of resident #6's Kardex, 12/16/25, reflected resident #6's activities were to include donuts and news, one-to-one activity, arts and crafts, ball toss/beanbag toss, barber, bingo, cooking, drumming circle, educational presentations, exercise, and games. Review of resident #6's activity assessment, dated 10/14/25, reflected resident #6 preferences included arts and crafts, church service, exercise, games, music, news, pets, social, television and movies.During an interview on 12/16/25 at 8:45 a.m., staff member E stated the activities department used the activities assessment done quarterly to determine activities needs.During an interview on 12/16/25 at 9:50 a.m., staff member A stated the facility had been a struggle to get activities to take charge and work (continued on next page)

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	275065	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Nursing Home of Anaconda	615 Main St Anaconda, MT 59711

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the activities programs. Staff member A stated she was aware the one-to-one visits and activities they should be doing were not being done but could not seem to get activities staff to work on the program. Staff member A stated, I guess we need to take a deficiency and write a Plan of Correction to get them moving. Staff member A stated she added all the activities to every Kardex regardless of preferences listed on the activities assessment findings. Staff member A stated the CNAs use the Kardex as their care plan. During an interview on 12/16/25 at 10:02 a.m., staff member E stated, We need to do more for the residents who stay in their rooms.During an interview on 12/17/25 at 9:10 a.m., staff member A stated she had a conversation with activities and determined the one-to-one charting was being falsified. Staff member A stated the staff were putting down residents were refusing, sleeping, or unavailable when they had not attempted the one-to-one activities. Review of the facility policy, Activities Meet Interest/Needs of Each Resident, dated 2/2023, reflected:- The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident: 1. An ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities designed to meet the interest of and support the physical, mental and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interviews and record review, the facility failed to maintain collaborative records for medication administration and care plans which aligned with the hospice agency for 2 (#s 2 and 15) of 3 hospice patients sampled. Findings include: 1. Review of resident #2's paper chart and EHR reflected no documents for hospice, including there not being a care plan or medication reconciliation for hospice and the resident. The care plan and medication list were requested from the hospice agency.Review of resident #2's faxed, Hospice Medication Profile, undated, reflected the following items were not listed on the facility medication list:- Alendronate Sodium 70 mg tabs, one time weekly on Tuesday for bone reabsorption,- Cholecalciferol (D3) 50 mcg tabs, one tablet daily for vitamin supplement, - Apixaban 5 mg tabs, one tablet twice per day for anticoagulation,- Escitalopram 10 mg tabs, one tablet daily for depression,- Famotidine 20 mg tab, one tablet daily GERD,- Diflucan 150 mg, one tablet with catheter changes and three days later for yeast infections,- Magnesium Hydroxide 30 mL every 72 hours as needed for constipation, - Melatonin 3 mg tabs, one tablet at bedtime for insomnia,- Potassium Chloride ER 10 MEQ, two tablets twice per day for hypokalemia,- Apoaequorin 20 mg, one tablet per day for memory,- Rosuvastatin Calcium 20 mg daily for CVA, and,- Torsemide 20 mg daily for edema. Review of resident #2's facility comprehensive care plan, dated 7/15/25, did not include information related to the frequency of the hospice staff visits, the hospice goals, or hospice interventions. 2. Review of resident #15's paper chart and EHR reflected no documents for hospice, including no hospice care plan or medication reconciliation. The care plan and medication list were requested from the hospice agency.Review of resident #15's EHR Order Summary, dated 12/17/25, reflected the following items not listed on the faxed Hospice Medication Profile:- Bisacodyl Rectal Suppository 10 mg every 72 hours as needed for constipation,- Guaifenesin Oral Syrup 100 mg/mL, 10mL every six hours as needed for cough,- Milk of Magnesia Oral Suspension 1200 mg/15mL, give 30mL every 72 hours as needed for constipation, and- Polyethylene Glycol 3350 Powder, give 17 grams once daily for constipation.Review of resident #15's facility's comprehensive care plan did not reflect information on the frequency of the hospice staff visits, the hospice goals, or hospice interventions. During an interview on 12/16/25 at 2:40 p.m., staff member A stated the facility was responsible for personal care and room and board for hospice residents. Staff member A stated that hospice visited and assessed residents, did spiritual visits, and the hospice staff attended care plan meetings quarterly. Staff member A stated the facility had Utilization Review meetings weekly, and the facility sent updated care plans to hospice, but had no documentation of the care plans being sent to hospice. Staff member A stated she or the Director of Nursing attended the hospice IDT every other week. Staff member A was not able to explain why the care plan and medication lists between hospice and the facility did not match. During an interview on 12/16/25 at 3:31 p.m., NF1 stated communication was ongoing almost daily with facility and she did not know why the orders and care plans did not align. Review of the [Hospice Name] and [Facility Name] Memorandum of Understanding, dated 5/19/25, reflected:- . [Hospice name] staff will be available 24 hours a day to give guidance and contact primary providers to obtain order changes if necessary to properly address the terminal illness and related symptoms.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, staff member B failed to ensure the security of all medications in a locked storage medication cart, limiting access to unauthorized personnel, and or residents. Findings include: During an observation on 12/17/25 at 7:43 a.m., staff member B was in a resident's room passing medications. The medication cart was parked outside of the room, in the hallway. The medication cart was not locked.During an interview on 12/17/25 at 10:54 a.m., staff member B stated the medication cart should be locked when a nurse was not by the cart. She stated she left her medication cart unlocked in the hallway earlier in the morning.Review of the facility's policy titled, Medication Floor Stock, last revised 8/17, showed:- .2. Medications contained in floor stock shall be stored in either locked cabinet or a tamper evident cart. Responsibility for security of the floor stock shall rest with the supervising licensed practitioner or supervising nurse overseeing the unit in which the floor stock is stored.