

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Gallatin Rest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 W Durston Rd Bozeman, MT 59715	
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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure opened food products were labeled with the date opened, and failed to properly store opened food products after opening. The failure placed all residents receiving food from the kitchen at increased risk of receiving expired, contaminated, or deteriorated food products. Findings include: During an observation of the kitchen dry storage and cold storage areas on 6/15/26 at 2:00 p.m., the following were observed: - An open, unsealed 25-pound bag of flour with approximately one quarter of the contents remaining; no open date. - Several open bulk spice containers, partially used (onion powder, nutmeg, paprika, garlic powder, thyme, and cloves); no open dates. - One bag of dry oat cereal rolled closed and stored on a preparation shelf; no open date. - Three opened and partially used gallons of milk stored in the refrigerator; no open dates. - One open box containing frozen hamburger patties in an unsealed manufacturer's plastic bag, exposing the patties to air; no open date. During an observation of the kitchen dry storage and cold storage areas on 6/16/26 at 3:40 p.m., the following were observed: - One open box of Cream of Wheat, unsealed and stored on a preparation shelf, with approximately one fourth of the contents remaining; no open date. - One open container of quick oats; no open date. - One refrigerated container labeled Garlic, with approximately one fourth of the contents remaining; no open date. - One refrigerated container labeled Caesar Dressing, with approximately three quarters of the contents remaining; no open date. During an interview on 6/15/26 at 2:00 p.m., staff member L stated opened food products should be labeled with the date opened to ensure proper stock rotation and prevent the use of outdated food products. When asked how long spices could be stored after opening, staff member L stated, I think about a year. During an interview on 6/16/26 at 3:40 p.m., staff member M was asked how long opened dry cereals would be kept after opening. Staff member M stated, Maybe a year, or 30 days? Review of a facility policy titled, Receiving, revised 2/23, showed, Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items . 5. All food items will be appropriately labeled and dated . 6. All food items will be stored in a manner that ensures appropriate and timely utilization based on the principles of 'first in-first out' (FIFO) inventory management . Review of an online reference titled, USDA Food Code 2022, last updated 5/1/26 and accessed on 6/22/26, showed, . all foods should be stored in a manner to preserve safety, integrity, and quality . prevent contamination . A request was made on 6/17/26 for policies pertaining to the storage of refrigerated, potentially hazardous foods, and frozen foods as clarification of a 6/16/26 request for food storage policies. No additional documentation was received by the end of 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 275066

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from physical abuse by agency staff for 1 (#27); failed to ensure a resident was free from verbal abuse by agency staff for 2 (#s 39 and 60); failed to ensure a resident was free from physical and verbal abuse by another resident for 2 (#s 46 and 59); and failed to ensure a resident was free from neglect of care for 1 (#13) of 8 residents sampled for abuse. The failure placed the residents at risk for physical injury, emotional distress, diminished quality of life, and loss of dignity. Findings include:1. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed NF2 was observed grabbing resident #27 by the arm and directing the resident into a seated position. The facility investigated the incident and substantiated the allegation of abuse. During an interview on [DATE] at 12:05 p.m., staff member B stated NF2 was a travel staff member completing a 13-week contract; however, following the abuse investigation, his contract was terminated. Staff member B stated there had been previous concerns addressed with NF2's travel agency regarding lack of motivation, attitude, and insubordination. Staff member B stated NF2 had been counseled by his agency for the prior concerns. During an interview on [DATE] at 3:00 p.m., staff member N stated she observed and reported the incident involving NF2 and resident #27. Staff member N stated NF2 was attempting to prevent resident #27 from standing. Staff member N stated that when resident #27 attempted to stand, NF2 yelled at the resident to sit down, grabbed the resident by the arm, forced the resident into a seated position, and did not let go. Staff member N stated NF2 then made a hand gesture as if reaching for an imaginary handgun. Staff member N stated, I intervened by taking the wheelchair from [NF2] and wheeling resident #27 to the end of the hall for a snack. Staff member N stated there had been previous concerns regarding NF2's behavior toward residents and lack of concern for resident well-being. Staff member N stated she had previously reported concerns to staff member B, including NF2 being sarcastic and uncaring toward residents in his care. Staff member N stated she believed NF2 did not think she would report the incident because they were friends outside of work; however, . my residents come first. Review of facility emails between NF2's travel agency and staff member B showed NF2 had previously been reported for concerns related to resident care and professionalism. On one occasion, NF2 was reported to have his head on a table while using his phone when he was assigned to monitor safety for a resident during a meal. On another occasion, NF2 was assisting a resident when the resident became upset and combative. Other staff intervened and removed the resident from NF2's proximity, and as the resident was being escorted away, NF2 made sarcastic comments toward the resident. Facility email communication between NF2's agency and the facility showed the agency would provide re-education on the previous concerns regarding NF2's behavior, although the email communication did not include documentation of the facility's monitoring of NF2's behavior. NF2 received a final warning on [DATE] for lack of professionalism, and on [DATE], the abuse incident involving resident #27 occurred. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of NF2's travel staff personnel record and email communication between the facility and NF2's agency failed to show evidence that the facility monitored NF2 for behavior and resident care improvement. Review of a facility policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated [DATE], showed, Prevention: . The facility will identify, correct, and intervene in situations in which abuse . of residents is likely to occur . 2. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed that a contract CNA had been verbally abusive to resident #39 and refused to provide care to resident #13. The reason for the refusal was that resident #13's speech was difficult to understand. The report showed the facility investigated the situation and determined verbal abuse had occurred, and the CNA's contract was terminated. The facility failed to ensure the staff member had the necessary training/oversight, and skills to address the resident's care needs and prevent abuse. During an interview on [DATE] at 8:37 a.m., resident #39 stated she remembered an incident with a CNA being verbally abusive to her. During an interview on [DATE] at 3:19 p.m., resident #13 did not remember the issue with a travel CNA from September of 2025. 3. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed resident #46 entered resident #59's room and was overheard saying, I am going to smack and punch you. A CNA corrected resident #46 and removed him from resident 59's room. At the time, it was believed to have been only verbal abuse. Later, resident #59 was found to have a resolving bruise near his right eye. When staff interviewed resident #59, he was able to answer only yes or no questions. The resident said he had been hit by resident #46. It was determined that resident #46 struck resident #59 at some point in time. Resident #46 was moved to another hall and counseled that physical violence and verbal threats are not acceptable. During an interview on [DATE]at 9:05 a.m., resident #46 stated he did not want to talk about the incident, and he was seeing a counselor and making progress. Resident #46 stated he knew resident #59 had died. 4. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed two staff members reported an agency employee (NF3) had verbally abusive interactions with resident #60 the evening of [DATE]. NF3 went into resident #60's room to tell her to shut up multiple times. The two staff members reported NF3 told resident #60 she had a severe migraine, and resident #60 needed to Grow up, and act like an adult and stop yelling. The facility reported incident findings showed the alleged violation was verified, and NF3 was removed from duty with her remaining contract time cancelled. The findings showed resident #60 had no memory of the incident, and ongoing behaviors had not increased following the incident. The facility failed to ensure the staff member had the necessary training, skills, and oversight to ensure a resident was not treated in a manner that was abusive. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #60's electronic medical record showed an admission date of [DATE] with a primary diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance. Review of resident #60's care plan, dated [DATE], showed resident #60 had behavioral concerns displayed by refusal of care, agitation, and restlessness related to her diagnoses of dementia with behavioral disturbance, anxiety, and depression. The care plan provided interventions to interact with resident #60 by approaching and speaking calmly, and to explain a procedure before starting, giving her time to adjust. NF3 did not follow the individualized care plan interventions for resident #60's conditions by interacting with her in a verbally abusive manner. During an interview on [DATE] at 10:38 a.m., staff member A stated that the incident with resident #60 and NF3 had occurred. Staff member A stated the facility relied primarily on contract nursing staff to fill resident care needs. Staff member A stated there had been abuse training before the incident and after the incident with nursing staff, and education on the need to immediately report any alleged abuse incidents. Review of a facility policy titled Abuse, Neglect and Exploitation, revised [DATE], showed: . It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by . implementing written policies and procedures that prohibit and prevent abuse. Verbal Abuse means the use of oral, written, or gestured communication or sounds that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse for 7 (#s 13, 27, 37, 39, 46, 55 and 59) of 8 residents sampled for abuse. The failure resulted in incomplete investigations, which did not show the evaluation of ongoing actions taken for the residents' well-being, did not identify resident-specific interventions, revise care planning, or document other measures implemented to protect residents and prevent recurrence of similar incidents. Findings include: 1. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed resident #37 and resident #55 were involved in a physical altercation without injuries. Staff intervened, separated the residents, and completed initial assessments. Resident #55 was transferred to another facility approximately six weeks after the incident. During an interview on [DATE] at 7:50 a.m., resident #37 stated, No one followed up with me, and no one told me to stay away from her (#55). Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed NF2 was observed grabbing resident #27 by the arm and directing the resident into a seated position. The facility investigated the incident, substantiated the allegation of abuse, and terminated the agency staff member; however, it did not provide evidence of any psychosocial monitoring, care planning, or revision of care post-event. During an interview on [DATE] at 1:42 p.m., staff member A stated the facility's post-incident process included educating staff as needed and, when applicable, verbally instructing staff to keep residents separated or monitor residents following an incident; however, the instructions were not documented in the electronic health record, kardex, or task list. Staff member A stated psychosocial follow-up visits or assessments were not completed for residents #27, #37, or #55 following the respective incidents and stated she did not know they were required. During an interview on [DATE] at 4:02 p.m., staff member N stated if there were instructions to monitor for behavioral changes or keep residents separated following an incident, the instructions would typically be communicated verbally during the report. Staff member N stated she was unaware whether those instructions were documented anywhere in the electronic health record and did not recall whether there were any post-event instructions for the incidents identified above. Review of the electronic health records for residents #27, #37, and #55 failed to show documentation of increased supervision, emotional support, counseling, psychosocial follow-up, monitoring of resident interactions, monitoring for behavioral changes related to the incidents, care plan revisions, or other protective measures implemented following the incidents to prevent recurrence. Review of a facility policy titled Abuse, Neglect and Exploitation, revised on [DATE], showed: . Protection of Resident . (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: . C. Increased supervision of the alleged victim and residents; D. Providing emotional support and counseling to the resident during and after the investigation, as needed; . G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of abuse. A request was made on [DATE] for documentation of post-incident psychosocial monitoring and evidence of measures implemented to prevent recurrence of the abuse events. No documentation was provided by the end of the survey. 2. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed that a contract CNA was verbally abusive to resident #39 and was neglectful with resident #13. The report showed the facility determined verbal abuse had occurred, and the CNA's contract was terminated. The report failed to show that the facility had attempted to determine if any other residents were affected by the contract CNA. During an interview on [DATE] at 8:37 a.m., resident #39 stated she remembered an incident with a CNA being verbally abusive to her. Resident #39 stated she felt the facility handled the situation. 3. Review of a Facility-Reported Incident, submitted to the State Survey Agency on [DATE], showed resident #46 entered resident #59's room and was overheard saying, I am going to smack and punch you. A CNA corrected resident #46 and removed him from resident 59's room. At the time, it was believed to have been only verbal abuse. Later, resident #59 was found to have a resolving bruise near his right eye. When staff interviewed resident #59, he was able to answer only yes-or-no questions. The resident said he had been hit by resident #46 but felt safe in the facility. It was determined that resident #46 struck resident #59 at some point in time. Resident #46 was moved to another hall and counseled that physical violence and verbal threats are not acceptable. During an interview on [DATE] at 9:05 a.m., resident #46 stated he did not want to talk about the incident and that he was seeing a counselor and making progress. Resident #46 stated he knew resident #59 had died. During an interview on [DATE] at 10:25 a.m., when staff member A was asked what she did to ensure no other residents were affected by the CNA's behavior, she stated, Could not tell you. I don't know that I talked to anyone. I may have asked staff to check with other residents.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to assess the risks and benefits associated with the use of a wander guard alarm and obtain informed consent for 1 (#1) of 5 residents sampled for wandering. The failure placed the resident at risk for restriction of movement and psychosocial distress; and failed to ensure a door to the outside of the facility was checked for eloping residents when alarmed, which had the potential to affect 5 residents who wander (#s 1, 3, 11, 18, and 34) of 23 sampled and supplemental residents. Findings include: 1. During an interview on 6/15/26 at 4:45 p.m., staff member D stated resident #1 could become agitated and wander during the early evening hours. Staff member D stated resident #1 used a walker for ambulation and had exhibited exit-seeking behaviors in the recent past; therefore, a wander guard alarm was placed on the resident's walker. During an interview on 6/16/26 at 8:40 a.m., NF4 stated she was not familiar with a wander guard alarm or how it was used. NF4 stated she did not recall being notified of the use of a wander guard alarm. During an interview on 6/18/26 at 8:30 a.m., staff member B stated she had never heard of obtaining a risk-benefit assessment or informed consent for the use of a wander guard alarm in her 20 years of experience. Staff member B stated wander guard alarm safety assessments and consents were not currently used in the facility. Review of resident #1's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/12/26, showed the resident had a Brief Interview for Mental Status (BIMS) score of 8; reflecting moderate cognitive impairment. Section E, Wandering, was coded Yes for wandering that placed the resident at significant risk of entering a potentially dangerous place. The assessment further showed the resident's wandering significantly intruded on the privacy or activities of others. Review of resident #1's electronic health record showed a physician order dated 5/17/26 for a wander guard alarm related to exit-seeking behavior. Review of resident #1's electronic health record showed an initial elopement assessment had been completed which identified the resident was at risk for elopement. Review of resident #1's electronic health record failed to show documentation evaluating the risks and benefits associated with the use of a wander guard alarm or informed consent from the resident's representative. Review of a facility policy titled, Resident Alarms, dated 4/18/22, showed: . Identification of risk . c. When alarms are in use or are under consideration, risks of adverse consequences related to the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alarms should be identified. Implementation of interventions . b. Alarms shall be initiated only . when the benefit of the alarm outweighs the risk associated with its use. . 5. Monitoring and modification . b. iii. Monitoring for adverse consequences associated with the use of the alarms, including psychosocial concerns. A request was made on 6/16/26 for documentation supporting the implementation and use of a wander guard alarm for resident #1, including a risk-benefit assessment and informed consent. No additional documentation was provided by the end of the survey. 2. During an observation on 6/17/26 at 7:36 a.m., the surveyor opened door 8, down a long hallway from the conference room, and an alarm went off. At 6/17/26 at 7:39 a.m., staff member C walked by the entrance to the hallway and looked down at door 8. Staff member C kept walking to the nurse's station and spoke with staff member D. Staff member C left the nursing station, walked past door 8's hallway, and looked down the hallway again. Staff member C did not check the door or the outside of it to see if a resident had left through the door. During an interview on 6/17/26 at 7:40 a.m., staff member D stated staff member C had asked if all the residents were accounted for, and staff member D said, Yes, and staff member C left. During an interview on 6/17/26 at 7:43 a.m., staff member E stated when a door alarm went off, staff were to check to see if a resident was outside and safe. During an interview on 6/17/26 at 8:05 a.m., staff member C stated when the alarm went off for door 8, she used her walkie-talkie to ask if anyone had eyes on the door. Staff member C then stated she walked to the hallway for door 8, looked down the hallway, and saw surveyors there, then walked to the nursing station. Staff member C stated, The smart thing to do would be to check outside the door for residents. Staff member C stated she did not check outside door 8 because staff usually went through that door. Staff member C stated there were a number of wanderers at the facility, including residents #s 1, 3, 11, 18, and 34. During an interview on 6/17/26 at 12:52 p.m., staff member B stated that when a door alarm went off, staff were to go and visually inspect the door, including for door 8. Staff member B stated there were a lot of deliveries outside door 8, but staff should still use the paging system and check the door to make sure residents had not gone through it. Staff member B stated the facility has had residents go through that door before. Review of the facility's policy, Staff Response to Door Alarm Activations, dated 2/20/26, showed, . 3. Visual Assessment: If the alarm was not set off by another staff member, then scan the immediate surroundings, hallways, and parking lots through windows or open doors to check for any exiting resident.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff adhered to infection control processes during an ostomy bag change and peri-care for 1 (#29); failed to perform proper hand hygiene and glucometer sanitizing during medication administration for 1 (#14); and failed to ensure enhanced barrier precautions were implemented for 1 (#40) of 23 sampled and supplemental residents. These deficient practices increased the risk of the spread of infections for residents in the facility. Findings include: 1. During an observation on 6/17/26 at 9:33 a.m., staff member C entered resident #29's room and donned gloves. Staff member C checked resident #29's ostomy bag. Staff member C did not perform hand hygiene prior to donning the gloves. During an observation on 6/17/26 at 9:34 a.m., staff member C disposed of the previous gloves, and donned a gown and a new pair of gloves. Staff member C did not perform hand hygiene before donning the new gloves. Staff member C opened the door to resident #29's bathroom, grabbed a trash bag, and doffed her gloves. Staff member C donned a new pair of gloves without performing hand hygiene prior. Staff member C then emptied resident #29's ostomy bag into the trash bag. Staff member C cleaned the ostomy bag. During an observation on 6/17/26 at 9:42 a.m., staff member C washed her hands with soap and water in resident #29's sink and donned new gloves. Staff member C cleaned resident #29's body with a warm, soapy washcloth. When staff member C went to clean resident #29's groove between her buttocks, she wiped the resident from the top of the groove of her buttocks towards her vaginal area. Staff member C then doffed her gloves and placed them on the resident's bed. During an observation on 6/17/26 at 9:52 a.m., staff member C doffed the single glove and gown and placed them in the trash. During an interview on 6/17/26 at 9:53 a.m., staff member C stated that the facility policy shows staff are to perform hand hygiene before and after gloving. Staff member C stated she did not do that when performing care on resident #29. During an interview on 6/18/26 at 8:38 a.m., staff member B stated that staff were expected to sanitize or wash their hands upon entering a resident's room. Staff member B stated that staff were to wash their hands or perform hand hygiene before donning gloves and after taking them off. Staff member B stated dirty gloves were to be disposed of immediately into the trash. Review of the facility's policy titled Hand Hygiene, revised 5/21/24, showed: . 6. 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. The Hand Hygiene Table on the back of the policy showed either soap and water or alcohol based hand rub (ABHR is preferred), was to be used for: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- After handling contaminated objects, - Before performing resident care procedures, and - After handling items potentially contaminated with blood, bodily fluids, secretions, or excretions. 2. During an observation and interview on 6/18/26 at 7:43 a.m., staff member I did not disinfect resident #14's glucometer before using it to obtain a blood sugar. Staff member I did not use EPA (Environmental Protection Agency) wipes to disinfect the resident's glucometer after use. Individual resident glucometers were all stored in the same white basket in the medication cart, touching. Staff member I did not perform proper hand hygiene after removing gloves and before prepping resident #14's medication after cleaning the glucometer. During an interview on 6/18/26 at 9:21 a.m., staff member I stated, .alcohol does the same thing ., regarding not using the EPA wipes to clean resident #14's glucometer after use. During an interview on 6/18/26 at 9:52 a.m., staff member B stated the staff were supposed to use the orange top EPA wipes to clean off the residents' glucometers, not the green top wipes, as they did not break down the blood. Staff member B stated she did not think the alcohol wipes would work and would have to look at the policy. Review of the facility's policy titled, Glucometer Disinfection, revised on 5/20/26, showed, .Policy Explanation of Compliance Guidelines . 3. The glucometers should be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus . 5. Procedure . k: After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe ., i: Discard disinfectant wipes in waste receptacle, . m: Perform hand hygiene. 3. During an observation on 6/16/26 at 8:46 a.m., resident #40 had a wound in his right groin and a suprapubic catheter. A gown sticker on the resident's name plate indicated he was on enhanced barrier precautions. Resident #40's wound was changed by NF1 and assisted by staff member F. Neither staff member was wearing an isolation gown or a mask at any time during the dressing change. After completion of the dressing change, staff member H and staff member J assisted resident #40 to get dressed and ready for the day. Staff members H and J were not wearing isolation gowns or masks during resident #40's care. During an interview on 6/16/26 at 8:51 a.m., staff member J was asked what PPE was to be used when a resident had enhanced barrier precautions. Staff member J stated she was supposed to perform hand hygiene with soap or hand sanitizer. Staff member J stated the PPE used depended on what was going on with the resident. Staff member J stated she did not remember any education related to enhanced barrier precautions. During an interview on 6/16/26 at 8:59 a.m., when staff member H was asked what she knew about enhanced barrier precautions, staff member H stated she was not sure what enhanced barrier precautions were. Staff member H stated she did not remember receiving any education related to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enhanced barrier precautions. During an interview on 6/16/26 at 9:18 a.m., staff member F stated she had been at the facility for two years. When asked what she knew about enhanced barrier precautions, staff member F stated it involved hand hygiene, changing gloves between residents and more PPE if the resident had something like clostridium difficile. When asked if there was any specific PPE to be used when a resident had a urinary catheter, a colostomy, or a wound, she stated there was nothing specific with regard to PPE. During an interview on 6/17/26 at 3:47 p.m., staff member G stated he had provided training on enhanced barrier precautions at least once during the past year. Staff member G denied performing monitoring and assessment of adherence to enhanced barrier precautions to determine the need for additional training and education. Review of the facility document titled, Infection Control Survey/New Policies Reportable Incidents, dated 6/25/25, showed a list of signatures of staff who had attended the training. The form did not provide an agenda or the presence of any handouts. No other training records were provided by the facility. Review of the facility policy titled, Enhanced Barrier Precautions, dated 6/16/24, showed, . EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and record review, the facility failed to implement, and maintain an effective behavioral health training program for all staff. This deficient practice had the potential to affect resident #14 and all other residents with behavioral health needs. Findings include: During an interview on 6/16/26 at 2:02 p.m., staff member H stated they had not received training on behavioral health services during their employment at the facility. During an interview on 6/17/26 at 8:11 a.m., staff member K stated they were not aware of any education regarding suicide attempts or ideations, staff member B provided that education so she would not know what was done. During an interview on 6/17/26 at 12:52 p.m., staff member B stated verbal education was given after resident #14's discharge from the emergency room. Staff member B stated she provided, . verbal coaching ., to staff regarding the resident's safety plan. During an interview on 6/18/26 at 9:31 a.m., staff member C stated they did not know the protocol if a resident attempted suicide or voiced suicidal ideations. Staff member C stated they had not received behavioral health training at the facility. Staff member C stated, To be honest, I have not had any education or training on anything here . A request was made on 6/16/26 for behavioral health training and in-service documentation. The facility could not provide the requested documentation by the end of the survey.		

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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 follow professional standards of practice when they did not use a resident's respiratory therapy (CPAP) equipment, failed to notify the resident's provider, and failed to document the reason for the non-use of CPAP therapy for 1 (#5) of 15 sampled residents. Findings include: During an interview on 6/16/26 at 11:24 a.m., resident #5 stated she did not use her CPAP/BiPAP machine because there was an electrical part missing. Resident #5 was not able to say how long she had been unable to use her machine. During an interview on 6/18/26 at 8:42 a.m., staff member I stated when she worked evening shifts, it was her responsibility to put on resident #5's CPAP mask at bedtime. Staff member I stated if there were parts missing, she would pull the equipment from use and notify the resident's provider. Staff member I stated she would document the circumstances in the resident's chart. Review of resident #5's diagnosis list showed she was admitted to the facility with a diagnosis of obstructive sleep apnea. Review of resident #5's physician order, dated 2/2/26, showed, BiPAP on each evening. Review of resident #5's MAR, dated 5/1/26 to 5/31/26, showed of the 31 opportunities to use the CPAP/BiPAP machine, 11 days were documented with the Chart Code 9 (Other/See Progress Notes). Review of resident #5's nursing progress notes, dated 5/1/26 to 5/31/26, failed to show any notes related to the use of resident #5's CPAP/BiPAP machine. Review of resident #5's MAR, dated 6/1/26 to 6/15/26, showed of the 15 opportunities to use the CPAP/BiPAP machine, 15 had a Chart Code 9 documented. Review of resident #5's nursing progress notes, dated 6/1/26 to 6/15/26, failed to show any notes related to the use of resident #5's CPAP/BiPAP machine. A request was made on 6/18/26 for documentation related to the missing power cord for resident #5's CPAP machine. There was no documentation received by the end of the survey.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to assess the safety and appropriateness of bed rail use and obtain informed consent for the use of two upper side rails for 1 (#49) of 23 sampled and supplemental residents. The failure placed the resident at risk for injury related to bed rail use, including entrapment, falls, and restriction of movement. Findings include: During an observation on 6/16/26 at 8:12 a.m., resident #49 was observed in bed with two upper side rails in the raised position. During an interview on 6/16/26 at 4:23 p.m., staff member A stated the facility did not complete a bed rail safety assessment or obtain informed consent for resident #49 because the resident was receiving hospice services. During an interview on 6/17/26 at 11:44 a.m., staff member B stated the facility should have documentation supporting the use of bed rails, including a safety assessment and informed consent from the resident or resident's representative. During an interview on 6/17/26 at 2:45 p.m., staff member A stated the facility did not have any policies pertaining to bed rails, . because we do not use them. Review of resident #49's electronic health record showed a physician order dated 7/22/25 stating, Bed Rail - 2 upper rails for safety and repositioning. Review of resident #49's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/16/26, showed the resident had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3. Review of resident #49's electronic health record failed to show documentation evaluating the risks and benefits associated with bed rail use or informed consent from the resident's representative for the use of the bed rails. A request was made on 6/16/26 for documentation supporting the use of bed rails for resident #49, including a bed rail safety assessment, informed consent, and facility policies regarding bed rail use. No documentation was provided by the end of the survey.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview, and record review, the facility failed to obtain necessary services for the behavioral health care needs of 1 (#14) of 15 sampled residents. This deficient practice increased the risk of declining mental health for the resident. Findings include: During an observation and interview on 6/15/26 at 3:56 p.m., resident #14 was sitting in her reclining chair. Resident #14 stated she previously attempted suicide; she tried hanging herself with her call light, and now she did not have a call light. A cord, approximately two inches long, was sticking out of the wall where the call light used to be. Resident #14 stated that when she needed help, she used the chair alarm on her bedside table. Resident #14 stated she saw a psychiatrist, a counselor who came to the building, and a nurse practitioner who, . does her meds. During an interview on 6/16/26 at 1:44 p.m., resident #14 stated her husband of 44 years passed away ten years ago. Resident #14 stated she had two children but lost her son when he was in his twenties, resulting in increased loneliness and depression. During an interview on 6/16/26 at 2:02 p.m., staff member H stated she had been working at the facility for approximately ten months. Staff member H stated she was not working on the day of resident #14's suicide attempt but did work the next day while resident #14 was still in the hospital. Staff member H stated she did not know resident #14 well enough to know her (mood/behavior) triggers and de-escalation routine. Staff member H stated that the triggers and de-escalation routine were in the Kardex if she needed to look them up. Staff member H stated that after resident #14's suicide attempt, there was no training on suicide prevention. Staff member H stated she would not know what to do if she walked into a room where a resident was attempting suicide or voicing suicidal ideations. Staff member H stated that before resident #14's suicide attempt, the resident was depressed and had spats with her roommate regarding the television volume and overall adjusting to her first time being at the facility. During an interview on 6/17/26 at 8:11 a.m., staff member K stated resident #14 did not attempt suicide, but voiced suicidal ideations on 5/13/26, and was sent to the emergency room. Staff member K stated that after resident #14 was discharged from the emergency room, her call lights were removed, and the staff was checking on her for a certain amount of time. Staff member K stated that resident #14 did not see a counselor or psychiatrist until after the emergency room visit for her suicidal ideations. Staff member K stated that resident #14 was at the facility before and did so well that she went to an assisted living facility (ALF). While at the ALF, resident #14 attempted suicide by an overdose of pills. From there, she was transferred to another skilled nursing facility (SNF). Staff member K stated resident #14's daughter was not happy with the care given at that SNF and had her moved back to this facility in March of 2026. Staff member K stated she was not aware of any education given regarding resident suicide attempts or ideations. Staff member K stated that the Director of Nursing (DON) provided that education, so she did not know what was done. Staff member K stated she was responsible for coordinating mental health referrals at the facility. Staff member K stated, I will be honest, I don't have a process for referral follow-up, and there was not a facility policy or procedure for following up on referrals placed for mental health services. Staff member K stated resident #14's first referral to counselling was placed at the Hospital by the LSW (Licensed Social Worker) through palliative care to the facility's in-house counselor, who was too busy to see resident #14. Staff member K stated she then requested a second referral to an additional counselor. Resident #14's first appointment with the other counselor was on 5/27/26. Staff member K stated that resident #14 went to the behavioral health clinic on 6/9/26, to see a psychiatrist. Staff member K stated her current referral process included receiving the referral order (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and filling out the paper referral form. Once the paperwork was completed, she stacked it on her desk. Then, when she saw the in-house counselor in the facility, she handed the stack of referrals to the in-house counselor. Staff member K stated she received resident #14's March referral for counselling, but kept missing the in-house counselor. Staff member K stated that anyone could have given the stack of referrals to the in-house counselor, but it did not happen. Staff member K stated on 5/5/26 that she sent a text message to the in-house counselor that a stack of paperwork was waiting for her. Then on 5/18/26, she sent a second text message to resident #14's provider for the new referral to a second counselor as the in-house counselor was too busy. During an interview on 6/17/26 at 12:52 p.m., staff member B stated resident #14 was previously in a different facility. At that facility, resident #14 was taken off her mental health medications, and did not do well. Staff member B stated resident #14 returned to this facility on 3/18/26. Staff member B stated she could not remember how she found out resident #14 was having suicidal ideations, but approached her on 5/13/26 to talk. Staff member B stated resident #14 expressed suicidal ideations due to not being on her mental health medications. Staff member B stated resident #14 said, Why do I need to live? Then the resident shared three specific plans to kill herself. She was sent to the emergency room at that time. Staff member B stated that resident #14 was discharged the same day with a safety plan in place. Staff member B stated she was not aware of an order for resident #14, dated 3/20/26, from the resident's provider for in-house counseling services. Staff member B stated that after resident #14 went to the emergency room on 5/13/26, a referral was placed to the in-house counseling services at that time. Staff member B stated she was not aware of a policy or procedure for mental health referrals, as staff member K was responsible for the mental health referral process. During an interview on 6/17/26 at 4:10 p.m., resident #14 stated, When I feel depressed, it makes it hard to function. You sit here and think of ways to die. Before counseling, it made it hard to eat and do activities. It makes me just want to be alone. Review of resident #14's provider orders, dated 3/20/26, showed, Referral to [Therapy Name] for treatment of depression/anxiety. Review of resident #14's provider visit note, dated 5/5/26, showed, . had something sad happen with one of her grandchildren, so has been struggling with that circumstance. Referral placed to counselor on admission. Facility has reached out to counselor who comes to the building, but referral has not yet gone through. Facility admin to reach out again today . She also has some stress/anxiety/conflict with her roommate. Facility admin to discuss moving rooms . Does not currently feel suicidal. Does have those ideas from time to time but reports no plan. Review of resident #14's social work progress note, dated 5/27/26, showed resident #14's first counselling appointment. This initial appointment occurred over ten weeks after the provider ordered counselling services on 3/20/26.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure all the irregularities noted by the pharmacist on the monthly medication regimen review were addressed and documented in the resident's medical record for 2 (#s 5 and 13) of 15 sampled residents. Findings include:1. Review of the [Pharmacy Name] Monthly Consulting document, dated February of 2026, showed the following nursing recommendation for resident #5, [Resident #5] needs an AIMS assessment due to Seroquel use. Review of resident #5's Assessments section of the EHR, dated between 1/1/26 and 6/15/26, showed one AIMS assessment was completed on 5/18/26. No other AIMS assessments were completed during that time.2. Review of the [Pharmacy Name] Monthly Consulting document, dated February of 2026, showed the following nursing recommendation for resident #13, Please clarify diagnosis for mirtazapine. It's being used for insomnia which is an off label indication and duplication of therapy due to zolpidem use. [Resident #13] has a diagnosis of anxiety which may be more appropriate. Review of resident #13's physician order, dated 2/4/26, showed an order for mirtazapine 15 mg at bedtime related to unspecified insomnia. The order was still active as of 6/15/26. Review of resident #13's nursing progress notes, dated 2/4/26 through 2/28/26, failed to show the rationale for not changing the mirtazapine indication to something other than insomnia. Review of resident #13's physician progress note, dated 2/6/26, failed to show a rationale for continuing the mirtazapine for insomnia. During an interview on 6/18/26 at 8:25 a.m., staff member B stated she was responsible for managing the medication regimen review process. Staff member B stated there were two different reports received monthly. One report was directed to nursing to address, and the other was for the attending provider to complete. When asked about how she maintained documentation showing the nursing recommendations were completed or the documentation of why the recommendation was not completed, staff member B stated she did not have any documentation but would start making copies of the nursing recommendations so the necessary documentation was maintained. Review of the facility's policy titled, Medication Regimen Review, dated 3/13/26, showed, The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities.		

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F 0887 Level of Harm - Potential for minimal harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to maintain documentation of staff education of the risks and benefits associated with the COVID-19 vaccine and documentation of the COVID-19 vaccination status for all staff members. Findings include: During an interview on 6/16/26 at 4:00 p.m., staff member A stated, I do not ask staff about their COVID status because it (the vaccine) is no longer mandatory. We don't provide any education to staff regarding COVID vaccines. During an interview on 6/17/26 at 3:47 p.m., staff member G stated the facility was not tracking COVID-19 status documentation unless it was self-reported by staff. A request was made on 6/16/26 for the COVID-19 vaccination status, consent or declination, education, and administration for staff member K. No documentation was provided prior to the end of the survey.		