STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275073	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faith Lutheran Home	1000 6th Ave N Wolf Point, MT 59201

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48262 Based on observation, interview, and record review, the facility failed to develop, implement, and operationalize a facility policy and procedure for grievances, and insure grievance information was readily accessible, to include the name and contact information for the grievance official; failed to provide residents with readily available grievance forms, as noticed by at least 1, resident (#196), of 14 sampled; and failed to provide residents with the option to file grievances anonymously. Findings include: During an interview on 4/23/25 at 2:00 p.m., resident #196 stated the resident council met monthly. Resident #196 stated the facility provided grievance forms, which were located near the nurse's station, but there was not a way to file a grievance anonymously. Resident #196 stated if a resident wanted to file a grievance, it was required to have the resident's name on the form, so the facility could address the grievance. During an observation on 4/23/25 at 2:50 p.m., a walk-through of the facility's common areas was conducted. No grievance forms were found to be readily available to residents. No posting of the name and contact information of the grievance official was found, and no secure receptacle was identified to file an anonymous grievance. During an interview on 4/23/25 at 4:30 p.m., staff member K stated grievance forms were located at the nurse's station, and a resident would need to ask a staff member for a grievance form. Staff member K stated social services also had grievance forms and could help a resident complete the form if assistance was needed. Staff member K stated residents would give the completed grievance form to a staff member, and the form would then be given to a supervisor or social services. Staff member K stated the facility did not have a way for residents to file a grievance anonymously or have a secure receptacle for residents who wanted to file grievances anonymously. A review of the facility's policy titled, [Facility Name] Policy and Procedure February 2000 Filing Grievances/Complaints, dated November 2016, showed the following: Policy Statement Our facility assists patients/residents/clients, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when such requests are made. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation 1. Any patient/resident/client, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other patients, residents, staff members, theft of property, etc. without fear of threat or reprisal in any form. 2. Grievances and/or complaints may be submitted orally or in writing. Written complaints or grievances must be signed by the patient/resident/client or the person filing the grievance or complaint in behalf of the individual . [sic]

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on interview and record review, the facility failed to ensure MDS assessments were completed, encoded, and transmitted, within the required timeframe, for 1 (#196) of 14 sampled residents, and failed to ensure the assigned staff member had the knowledge necessary to correct MDS transmission errors. The failures resulted in inaccurate and missing MDS data, which was identified during the annual recertification survey process. Findings include: 1. During an interview on [DATE] at 8:15 a.m., staff member D said she did not know how to correct or add a re-entry MDS when a resident returned from the hospital. Staff member D said resident #196 did not have a re-entry MDS and was now due for a quarterly assessment. Staff member D said she recently started completing MDS assessments and only had three days of MDS training at the facility. Review of resident #196's nurse progress note, dated [DATE], showed resident #196 was discharged to the hospital on [DATE]. Review of resident #196's nurse progress note, dated [DATE], showed resident #196 was readmitted to the facility on [DATE]. Review of a screen-shot of resident #196's MDS assessment list showed resident #196 was discharged from the facility on [DATE]. The assessment list showed the next MDS entered was for, . Nursing home: tracking (entry/expired). The assessment list did not show resident #196 as having a re-entry MDS completed. 48268 2. During an interview on [DATE] at 1:05 p.m., staff member D stated she was responsible for submitting the facility's MDS reports. Staff member D stated she had been at the facility since [DATE], and had received approximately one week of MDS training from a previous employee. Staff member D stated she was unaware of any MDS submission errors and was also unaware of how to locate error messages or how to correct them. Review of CMS report titled, CASPER Report 0004D Provider Full Profile, dated [DATE], showed no facility reporting for care-level resident characteristics. Review of the facility-specific IQIES quality reporting status report, showed multiple errors, including incorrect Medicare Beneficiary Identifier, duplicate assessments, late assessments, and resident mismatches.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48262 Based on interview and record review, the facility failed to revise a resident care plan to address comfort care for 1 (#31) of 14 sampled residents. This failure placed the resident at risk for not receiving appropriate comfort care measures. Findings include: During an interview on 4/23/25 at 7:30 a.m., staff member M stated resident #31 had a recent change in condition. Staff member M stated resident #31 decided at the time not to go to the hospital and instead requested comfort care. Staff member M stated resident #31 had recently changed her POLST to reflect comfort care only. Staff member M stated any treatment resident #31 may need would be provided at the facility. During an interview on 4/23/25 at 1:05 p.m., staff member D stated she was responsible for updating the resident care plans. Staff member D stated she updated care plans as needed after the facility's daily morning meeting. Review of resident #31's medical provider note, dated 3/5/25, showed resident #31 was seen by the medical provider for concerns related to not eating or drinking, since diagnosed with Influenza A, the week prior. Medical provider documentation showed: Review of Systems . Psych: Voices desire to hold any heroics in her care. Absolutely refuses any hospitalization or invasive treatments . States she is ready to go and has been for awhile. [Family member] is present in room for this discussion and agrees with [resident #31] to get comfort care only . Assessment/Plan . 2. Failure to thrive in adult Will change code status to DNR with comfort care only and no hospitalization s. Will update POLST form. Family in attendance at visit and in agreement to her decision. Review of resident #31's POLST, dated 3/5/25, showed resident #31's code status was DNR with comfort care only. Review of resident #31's dietician note, dated 3/11/25, showed resident #31 was recently treated for influenza A and pneumonia. The dietician's note also showed resident #31 reported she had no energy, a poor appetite, and had decided on comfort care only. Review of resident #31's care plan, dated 3/26/25, failed to show a focus area, goals, or interventions which addressed the resident's needs specific to comfort care.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 14005 Based on interview and record review, the facilty failed to ensure residents who received dialysis were provided services, consistent with professional standards of practice, to include physician orders for the dialysis, for 1 (#22) of 14 sampled residents. The deficient practices placed the resident at risk for pre-dialysis and post-dialysis complications. Findings include: During an interview on 4/22/25 at 8:29 a.m., resident #22 said she had been getting dialysis prior to her admission to the facility. Resident #22 said she goes to a dialysis center in another town on Monday, Wednesday, and Friday. Resident #22 said she left the facility at approximately 11:00 a.m., and the dialysis ran for three hours and fifteen minutes. Resident #22 said she returned to the facility at approximately 4:30 p. m. on dialysis days. Review of resident #22's current physician orders, dated 4/22/25, showed the resident did not have a physician order for her dialysis treatment. Review of resident #22's physician order received on 4/23/25, showed the physician ordered for hemodialysis. The physician dialysis order was dated 4/23/25. Review of resident #22's initial care plan, dated 2/27/24, showed resident #22 started dialysis in August 2023. The medical record did not show a physician had ordered resident #22 to receive dialysis until 4/23/25.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14005 Based on observation, interview, and record review, the facility failed to ensure the dietary manager completed a certification program approved by a national certifying body or had higher education in a related field. This had the potential to affect residents and their nutritional status, or meal safety for those who consumed food prepared and served by the facility. Findings include: During an observation of the kitchen, on [DATE] at 7:50 a.m., no documentation of advanced training for the dietary manager was posted or readily available. During an interview on [DATE] at 8:00 a.m., staff member E said she had come out of retirement a couple months ago when the dietary manager left. Staff member E said she would help the facility until they could advertise and find a new manager. During an interview on [DATE] at 4:01 p.m., staff member A said the interim dietary manager came out of retirement to help the facility. Staff member A said staff member E's certified dietary manager certification expired about three years ago. Staff member A said there was no certified dietary manager on staff. Concerns were identified related to the dietary department services. Refer to F812 - Food Procurement, Store/Prepare/Serve/Sanitary services for further detail.

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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. 14005 Based on observations, interviews, and record review, the facility failed to ensure sanitary conditions were maintained throughout the kitchen and the dietary storage areas; failed to ensure kitchen staff labeled and dated food in the coolers; and failed to maintain a clean kitchen environment. The deficient practices increased the risk for the development of foodborne illnesses and unsanitary conditions, for all residents who received food from the kitchen. Findings include: During an observation of the kitchen, during the initial tour on 4/22/25 at 7:25 a.m., the following observations were made: - One pitcher full of fluid was observed in the reach-in cooler. The pitcher was unlabeled and undated. - One gallon of 2% milk, opened, and not dated. - One quart of Half and Half, opened, and not dated. - The inside of the microwave was splattered with food particles. - The meat slicer had white and brown particles of debris on the cutting surface and base. - Large containers of spices were opened, not dated. - Cinnamon and cumin spice containers appeared soiled and were sticky to touch. - Numerous cups of red jellied products were not labeled or dated in the walk-in cooler. - A bowl containing a white fluffy substance was not labeled or dated in the walk-in cooler. - A large metal pan containing a mixture of pasta and sliced meat was not labeled or dated in the walk-in cooler. - A bag of seven chicken breasts were thawed in a metal pan on the top shelf of the walk-in cooler. The chicken breasts were dated 2/25/25. During an observation and interview on 4/22/25 at 7:40 a.m., staff member F was observed with a mustache and beard. Staff member F was in the food preparation area and was not wearing a beard or mustache cover. Staff member F said he never worked with the food slicer, but he thought it got cleaned every time it was used. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 4/22/25 at 8:00 a.m., staff member E said dented cans are placed on a special shelf and if dented, they are sent back for credit. During an observation, one can of pumpkin, one can of diced pears, and one can of tomato soup, all dented, were observed on the shelves where undented storage cans were stored and taken by staff or use. Staff member E said the facility has a person that comes in and does deep cleaning on Thursday and Friday every week. Staff member E said the cleaning must be behind schedule due to the Easter holiday. During an observation and interview on 4/22/25 at 12:30 p.m., staff member G was observed with a beard and mustache. Staff member G was in the food preparation area and was not wearing a mustache or beard cover. Staff member E said she knows the staff with beards should wear a bear cover. Staff member E asked staff member G to immediately put on a beard cover. During an observation on 4/23/25 at 8:07 a.m., staff member F was observed in the kitchen without a beard or mustache cover. Review of a facility temperature document, untitled, located on the reach-in refrigerator showed: - Ten days in January 2025 with no temperatures documented, - Five days in February 2025 with no temperatures documented, however temperatures were documented for February 29, 30 and 31, - Four days in April 2025 with no temperatures documented. Review of the facility document titled, DIETARY FRIDGE TEMPERATURE showed: - Three days in April 2025 with no temperatures documented. Review of facility document titled, DIETARY FREEZER TEMPERATURE log showed: - Three days in January 2025 with no temperatures documented, - Three days in April 2025 with no temperatures documented.

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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. 14005 Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precautions were followed for 1 (#22) of 14 sampled residents; and failed to to maintain an adequate infection surveillance and antibiotic stewardship program and ensure policies and procedures were reviewed and revised annually for the Infection Prevention and Control Program. The deficient practices had the potential to increase the risk of infections within the facility. Findings include: 1. During an interview on 4/22/25 at 8:49 a.m., resident #22 said she had a central IV (intravenous) catheter for dialysis. Resident #22 said the nursing staff wore gloves, but never wore gowns when providing personal care. During an observation and interview on 4/22/25 at 3:05 p.m., staff member H was observed assisting resident #22 prepare for a shower. Resident #22 had a central IV catheter in her upper right chest. The IV site was covered, but the ends of the tubing were not covered. Staff member H was wearing gloves while taping a piece of plastic over the IV insertion site and around the exposed IV catheter tubing. No gown was worn during the care observation. Staff member H said she had been trained on enhanced barrier precautions, but since the IV insertion site was covered, she said she did not need a gown. Gloves were available, but no other personal protective supplies were available in or near resident #22's room. Review of resident #22's care plan, dated 4/23/25, showed an intervention directing the staff to use enhanced barrier precautions when caring for the central IV catheter. 51111 2. During an interview on 4/23/25 at 8:07 a.m., staff member C stated the facility did not use McGeer criteria (infection surveillance tool) in the infection control program until about six months ago, which is about the time staff member C stated he started the position. During an interview on 4/23/25 at 9:02 a.m., staff member D stated she started in her current position at the end of January this year. Staff member D stated she did not know what the facility was doing specifically with the antibiotic stewardship program prior to January 2025, she could not speak to what was or was not in place. Staff member D stated there was no current enhanced barrier precautions policy in place, only guidance for staff to follow. Staff member D stated the facility's corporate QAPI board needed to approve and sign off on the enhanced barrier precautions policy before it would be utilized. During an interview on 4/23/25 at 12:43 p.m., staff member B stated she helped work on infection control items along with staff member D. Staff member B stated she started her role in September of 2024. Staff member B stated NF3 worked in the facility until the end of December of last year and oversaw the infection prevention program. Staff member B stated NF3 and herself reviewed the former antibiotic stewardship system in place. Staff member B stated she and NF3 decided it was not a complete program and started things over in September of last year. Staff member B stated the facility started using McGeer criteria in September of last year. Staff member B stated she was unaware if there was a break in services of the infection preventionist role between NF2's and NF3's employment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a facility document titled, Long Term Care Facility Component-Annual Facility Survey, showed, the facility reported for survey year 2025 a total of three times in the past year a new employee had to take over the infection preventionist role. Review of a facility document titled, Monthly Infection Control Log (Line List), showed: . Reporting Period Oct. 1 to Oct. 31, 2024 . Types of infections . - UTI no cath: 4 . - URI: 1 . - Eye: 3 . - # New Cases colonized (not infected) with antibiotic resistant organisms: 8 . 1. Started McGeer Criteria 2. Started Ab Stewardship & [72 hour] stop Oct. 31 . [sic] Review of the facility's Infection Prevention and Control Program policies showed the following: - Infection Control - Antimicrobial Stewardship Policy and Procedure, Origination September 2024, last revised September 2024; - Infection Control Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, Origination September 2024, last revised September 2024; - [Facility Name] Pneumoncoccal Immunization Policy and Procedure, [sic] last revised June 2023, next review due June 2024; and, - [Facility Name] Influenza Policy and Procedure, last revised December 2017, next review June 2024.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on interview and record review, the facility failed to ensure documentation for screening of medical contraindications, education, and signed consent or declination by the resident or their responsible party for the influenza vaccination for 4 (#s 3, 7, 13, and 31) of 5 sampled residents. This increased the risk of residents not being informed of risks and benefits to the vaccination and verification of resident or responsible party authorization. Findings include: During an interview on 4/23/25 at 3:10 p.m., staff member A stated staff member D looked and could not find influenza vaccine consents or declination forms for resident #s 3, 7, 13, and 31. Review of a facility document titled, 2024-2025 flu vax, [sic] showed resident #s 3, 7, 13, and 31 received the influenza vaccination on 10/18/24. Review of resident #s 3, 7, 13, and 31 vaccine records did not show a vaccine consent form provided, documented, or signed by the resident or responsible parties for the influenza vaccine. The records did not have documentation of screening for medical contraindications to the vaccine or education provided prior to administration of the vaccine explaining the risks and benefits of the influenza vaccination. A request was made to the facility on [DATE] for influenza vaccine consent or declination forms for resident #s 3, 7, 13, and 31. No documentation was received by the end of the survey. Review of a facility document titled, [Facility Name] Influenza Policy and Procedure, last approved June 2023, showed: . All residents and patients will be immunized against influenza as recommended by the Advisory Committee for Immunization Practices (ACIP). The vaccine will be provided to all residents . unless medically contraindicated, or the resident or responsible party refuses . 2. Obtain informed verbal consent before the immunization is administered and will be documented on the Resident's Vaccine Administration Record. 3. An informed verbal consent may be obtained by giving the resident, patient, or responsible party a copy of the current Vaccine Information Statement (VIS) and by providing an opportunity for their questions to be answered. 4. If the resident or patient or responsible party refuses an immunization, it should be documented in the permanent medical record. The resident or responsible party should be provided with an educations program and the immunization offered again . 5. The resident or patient will be screened for contraindications before each dose of vaccine is given. All contraindications will be recorded in the permanent record . [sic]