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	05/21/2026

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

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to submit reportable incidents to the State Survey Agency, within 24 hours of the incident, for 7 (#s 13, 14, 15, 22, 25, 29, and 38) of 17 sampled residents. Findings include: 1. Review of a Facility-Reported Incident, dated 3/2/26, showed there was an incident involving resident #25 making derogatory statements towards resident #13. The report showed when resident #25 was asked to stop, he became angry, and threw two empty, and one partially full cup of juice, at the staff members present during the incident. The incident was submitted to the State Survey Agency via the online reporting portal on 3/5/26, three days after the incident occurred. During an interview on 5/20/26 at 2:15 p.m., staff member C stated they were the only staff member who knew how to submit a reportable incident via the online reporting portal, so if an incident occurred on a weekend, it had the potential to be reported late. Staff member C stated she did not know why the incident involving resident #13 and #25 was not submitted timely, within 24 hours, to the State Survey Agency. 2. Review of a Facility-Reported Incident, dated Saturday, 2/28/26, at 1:30 p.m., showed there was a verbal altercation between resident #29 and resident #25. The incident was submitted to the State Survey Agency on 3/5/26, five days after the incident occurred. During an interview on 5/20/26 at 2:15 p.m., staff member C stated she was the only person who had access to the online reporting portal. Staff member C stated if an incident occurred on a weekend or holiday, a report was not completed until she was back in the facility. 3. Review of a Facility-Reported Incident, dated 1/24/26 at 9:45 a.m., showed resident #22 became verbally aggressive with resident #15. Resident #22 threatened to hit resident #15 with a crossword book he had in his hand. The facility reported the incident to the State Survey Agency on 1/26/26, two days after the incident occurred. Review of a Facility-Reported Incident, dated 12/21/25 at 2:30 p.m., showed resident #14 became verbally aggressive to resident #38 in the activities room. The facility reported the incident to the State Survey Agency on 12/30/25, nine days after the incident occurred. During an interview on 5/19/26 at 3:24 p.m., staff member C stated the incidents, which occurred between resident #s 14 and 38 on 12/21/25, and resident #s 15 and 22 on 1/24/26, were not reported to the State Survey Agency within 24 hours because she was out of the facility, and reported the incidents as soon as she returned. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Abuse Policies, dated November 2016, showed: . 4. (1)All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide 12 hours of in-service training per year, including dementia management, for Certified Nursing Assistants. This deficient practice had the potential to affect all residents with dementia or altered cognition in the facility. Findings include:During an interview on [DATE] at 9:30 a.m., staff member G stated she routinely worked in the memory care unit and received general orientation when she started working at the facility. Staff member G stated she had not received any additional training related to the care of residents in the memory care unit or any dementia training in general. Staff member G stated she had not received any training on how to deal with residents who have displayed problematic behaviors. During an interview on [DATE] at 7:47 a.m., staff member H stated she had experience working with residents with dementia. Staff member H stated she had not received any additional dementia training since starting at the facility. During an interview on [DATE] at 7:52 a.m., staff member I stated she had been employed by the facility since the beginning of 2025. Staff member I stated she had not received any education or training related to dementia care or how to deal with resident behaviors. Staff member I stated she worked in the memory care unit at least once every two weeks. During an interview on [DATE] at 8:00 a.m., staff member C stated she thought it was the responsibility of each individual CNA to ensure they had at least 12 hours of in-service training annually. Staff member C stated all staff were required to complete annual training and dementia care had not been part of the annual online training. Staff member C stated dementia care training had been added recently and would be required of all CNAs within the next month. Review of the facility's annual online training topic list, received on [DATE], failed to show any topics related to the care of residents with dementia or how to deal with resident behaviors. Review of all in-person training provided for CNAs in the past 12 months showed the following: - [DATE], air mattress training,- [DATE], ambulating resident with a gait belt,- [DATE], CPR,- [DATE], C. difficile education, - [DATE], MDS Section GG Functional Abilities, and- [DATE], enhanced barrier precautions

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure the resident, and/or the resident's representative, were made aware of the risks and benefits associated with the use of psychotropic medications prior to the start of treatment for 2 (#s 2 and 3) of 17 sampled residents. Findings include:1. Review of resident #2's physician orders showed the following psychotropic medication was being given to the resident:- 12/30/25 to 4/30/26: alprazolam 0.25 mg tablet twice daily, as needed, for anxiety.Review of resident #2's EHR, accessed between 5/18/26 and 5/21/26, failed to show documentation the resident, or their representative, were made aware of the risks and benefits of using the above listed psychotropic medication.2. Review of resident #3's physician orders showed the following psychotropic medications were being given to the resident:- 12/30/25 to 1/2/26: lorazepam 0.5 mg tablet three times daily, as needed, for anxiety.- 1/3/26 to 5/21/26: lorazepam 0.5 mg tablet send one tablet with resident to dialysis for possible anxiety while there.- 5/6/26 to 5/21/26: lorazepam 0.5 mg once daily, as needed, after dialysis due to possible anxiety.Review of resident #3's EHR, accessed between 5/18/26 and 5/21/26, failed to show documentation the resident, or their representative, were made aware of the risks and benefits of using the above listed psychotropic medications.During an interview on 5/20/26 at 3:00 p.m., staff member E stated the facility did not require signed risks and benefits consent documentation for residents taking 'as needed' psychotropic medications.A request was made on 5/20/26 for resident #2 and #3's risks and benefits consent documentation for psychotropic medication use. No documentation was received from the facility by the end of the survey.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure an as needed psychotropic medication was limited to 14 days, unless the rationale for continuing the medication was documented by a medical provider, for 1 (#2) of 17 sampled residents. Findings include:Review of resident #2's medication administration record, dated 1/1/26 through 4/30/26, showed an order for alprazolam 0.25 mg, take two tablets, twice daily, as needed for anxiety.Review of resident #2's medication administration record, dated 5/1/26 through 5/19/26, showed an order for alprazolam 0.5 mg one tablet daily, as needed for anxiety.Both of resident #2's psychotropic medication orders for alprazolam did not include an end or stop date, and were not limited to 14 days.During an interview on 5/26/26 at 3:30 p.m., staff member F stated as needed psychotropic medication orders were limited to 14 days. Staff member F stated the alprazolam could have been missed during the medication regimen review for resident #2.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to accurately complete a Quarterly Minimum Data Set (MDS) assessment for a resident receiving hypoglycemic medication for 1 (#7); and failed to accurately complete a Comprehensive MDS assessment for 1 (#5) of 17 sampled residents. Findings include: 1. Review of resident #7's electronic medical record showed the resident was diagnosed with Diabetes Mellitus and was currently prescribed Trulicity (a glucagon-like peptide-1 receptor agonist) to be given once a week subcutaneously. Review of resident #7's Quarterly MDS assessment, with an ARD of 3/14/26, showed, Section N: Mediations, Insulin, Insulin injections Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days (N0350A). The answer marked by the facility was 1. During an interview on 5/21/26 at 8:49 a.m., staff member D stated she was new to the MDS role. Staff member D stated resident #7 was prescribed Trulicity and received an injection once a week. Staff member D stated the medication was listed as an insulin, and she assumed it would be accurate, under section N of the MDS, Insulin injections, to enter 1, signifying the resident was on insulin. Staff member D stated she misunderstood the resident assessment instrument, and it was her error. 2. During an interview on 5/21/26 at 8:50 a.m., staff member D stated when a resident had a Wander Guard alarm, she coded it under Section P: Restraints and Alarms, Restraints used in bed: other (P0100D), used daily, Restraints used in chair/out of bed: other (P0100H) used daily, and Alarms, Wander/Elopement Alarm (P0200), used daily. Staff member D stated she believed if the alarm was hindering a resident's independence, it was also a restraint. Review of resident #5's Comprehensive MDS assessment, with an ARD of 4/24/26, showed Section P: Restraints and Alarms, Restraints used in bed: other (P0100D), used daily, Restraints used in chair/out of bed: other (P0100H) used daily, and Alarms, Wander/Elopement Alarm (P0200), used daily. The Wander Guard alarm for resident #5 did not meet the criteria required to be a restraint as it could be easily removed and did not restrict normal access to the resident's body. A Wander Guard is also not considered a position change alarm that would cause the potential inhibition of movement.

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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 the pharmacist identified and reported an as needed psychotropic medication being used in excessive duration for 1 (#2) of 17 sampled residents. Findings include:Review of resident #2's Medication Administration Record, dated 1/1/26 to 5/21/26, showed alprazolam 0.25 mg twice a day, as needed for anxiety. This was an active prescription written on 12/31/25.Review of resident #2's Medication Regimen Reviews, dated 1/1/26 to 4/30/26, showed the following recommendations by the pharmacist:- January 2026 - Do not crush omeprazole, levothyroxine take on an empty stomach, rinse mouth after taking Symbicort.- February 2026 - Do not crush omeprazole, levothyroxine take on an empty stomach, rinse mouth after taking Symbicort, do not crush duloxetine.- March 2026 - Do not crush omeprazole, levothyroxine take on an empty stomach, rinse mouth after taking Symbicort, do not crush duloxetine.- April 2026 - no issues.The Medication Regimen Reviews showed a lack of monitoring for resident #2's as needed psychotropic medication, alprazolam.During an interview on 5/26/26 at 3:30 p.m., staff member F stated he reviewed all residents taking psychotropic medication monthly. Staff member F stated he was not sure why resident #2's prescribed alprazolam was not on the medication regimen review, and a gradual dose reduction was not recommended. Staff member F stated he could have missed the medication when completing the medication reviews.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the COVID-19 vaccination status (received or refused) for staff member E. Findings include:During an interview on 5/20/26 at 8:59 a.m., staff member C stated she was not aware the facility needed to offer employees education on where a COVID-19 booster vaccination could be obtained and the facility's responsibility to document in the employee's record they had been educated and given a referral on where to obtain the booster vaccination. During an interview on 5/20/26 at 2:30 p.m., staff member E stated she had received two COVID-19 vaccinations in 2021, but no additional vaccinations since. Staff member E stated she did not sign a declination form for additional booster vaccinations.Review of staff member E's COVID-19 vaccination documentation, dated 7/8/21, showed staff member E received COVID-19 vaccinations on 1/6/21 and 2/3/21.Review of the facility's policy titled, 7.91 SARS-2 Vaccine Program, dated July of 2021, showed: POLICY:Immunization of health care personnel (HCP) is recommended help prevent spreading of the disease to patients, friends, family and staff and to protect me from serious illness if I get infected.PROCEDURE:Education of HCP regarding the benefits of SAR-2 vaccination and the potential health consequences of SARS to them selves and preventing health-care-associated illness. employees are encouraged to participate the vaccination program form the county Health Department. HCP will be requested to sign a declination statement if they elect not to get the vaccine for any reason. [sic]