STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275084	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View of Cascadia	10 Mountain View Dr Eureka, MT 59917

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record review, the facility failed to ensure a resident was served a meal when tablemate's were served, and the resident had to wait 20 minutes while the other residents at the table finished their meals, for 1 (#43); and failed to ensure catheter bags were covered with a dignity bag in public areas for 1 (#15) of 15 sampled residents. Findings include: 1. During an observation on 6/3/25 at 8:21 a.m., resident #43 was seated at the dining table across from another resident. This resident had his plate and was eating breakfast. Resident #43 did not have her food. Residents at nearby tables were served their plates in no particular order. During an observation on 6/3/25 at 8:37 a.m., resident #43's tablemate had finished his breakfast. Resident #43 was still waiting for her plate. She wondered out loud if she could leave. During an observation on 6/3/25 at 8:44 a.m., resident #43 was served her breakfast. Resident #43 waited 23 minutes for her plate while those at her table and surrounding tables ate their meals. During an interview on 6/4/25 at 4:23 p.m., staff member J stated the seating chart in the dining room stayed consistent. Staff member J stated they tried to serve all residents at the table at the same time, however they also got a lot of the minced and moist or pureed plates out together instead of switching back and forth on consistencies. Review of resident #43's care plan, with an initiation date of 5/24/24, showed, [Resident #43] is at risk for being nutritionally [un]stable [related to] dementia, poor dentition, need for mechanically altered diet and slow weight loss. [sic] 2. During an observation on 6/3/25 at 12:25 p.m., resident #15 was seated at the table in the dining room waiting for lunch. Her catheter bag was on the side of her chair, uncovered. During an observation on 6/3/25 at 2:51 p.m., resident #15 was watching a movie in the day room with several other residents. Her catheter bag was on the side of her chair, uncovered. During an observation and interview on 6/4/25 at 8:07 a.m., resident #15 was seated at the table for breakfast. Her catheter bag was on the side of her chair, uncovered. Staff member C stated she should have a cover over the bag, and the facility had several cloth ones which had been made for that reason. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #15's care plan, with an initiation date of 11/28/23, showed, . has a supra pubic catheter. Position catheter bag and tubing below the level of the bladder. Cover with privacy bag . The staff failed to ensure the resident's dignity was maintained related to covering the catheter.

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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 inform and include the residents' guardian in the decision-making process for initiating physical and occupational therapy services, for 3 (#s 15, 19, and 44) of 15 sampled residents. This deficient practice caused the representative frustration and limited their ability to participate in resident care. Findings include: 1. During an interview on 6/4/25 at 3:36 p.m., NF2 stated she was concerned she was not informed by the facility that resident #19 was receiving therapy services. She stated she only became aware the resident was receiving therapy services when she was contacted about needing to sign a form to discontinue physical therapy. NF2 stated she was the legal guardian for resident #19, and the resident was not capable of making informed decisions for her own care. She stated she would have liked to be part of the decision-making process for resident #19, regarding her therapy services, so she could have attended the evaluation to discuss therapy goals for the resident. Review of resident #19's Physical Therapy Evaluation and Plan of Treatments, showed continuing certification periods from 12/17/24 - 5/19/25. Review of resident #19's progress notes, therapy notes, and consents to treat, from 12/17/24 to 6/4/25, failed to show NF2 was informed and included in the decision-making process for initiating physical therapy services for the resident. During an interview on 6/5/25 at 9:26 a.m., staff member H stated it was necessary to obtain consent prior to starting therapy services. She stated if a resident was not cognitively competent to consent to therapy services their legal representative should be notified prior to initiating services. She stated this consent could be obtained by the therapist or the nursing staff. Staff member H stated, there was potential for improvement that they should have notified NF2 about for resident #19's initiation of therapy services, but failed to do so. During an interview on 6/5/25 at 9:47 a.m., staff member B stated it was the expectation for the resident or their legal representative to be notified when there was a change in treatment. She stated the resident, or their representative should be contacted when a need for therapy services was identified to get consent for services. She stated her expectation would be for therapy to notify the resident or their representative when therapy services were involved. 2. During an interview on 6/4/25 at 3:30 p.m., NF2 stated they were unaware resident #15 had started therapy in March 2025. NF2 stated it was frustrating to be blind-sided and not included in the goal setting process for the resident with a new therapy initiation. During an interview on 6/5/25 at 10:22 a.m., staff member H stated resident #15 was currently in therapy, and her guardian had not been notified back when she started. Review of resident #15's Occupational Therapy Evaluation and Plan of Treatment notes showed a continuous certification period of 3/6/25 - 5/4/25. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 6/4/25 at 3:30 p.m., NF2 stated she was unaware resident #44 had been in therapy for strength and conditioning since August of 2024, and stated, I only knew about the lymphedema therapy. NF2 stated she was frustrated at not being included for resident #44's physical therapy treatment and goals, after asking the facility repeatedly to include her, and she was concerned because resident #44 had been walking independently for a while. During an interview on 6/5/25 at 10:22 a.m., staff member H stated resident #44 was currently in physical therapy, and her guardian was made aware as of yesterday during the case conference, and stated, I don't know if she was made aware when she started (in August 2024), but I see we can improve how we communicate that better now. Review of resident #44's Physical Therapy Evaluation and Plan of Treatments, showed continuing certification periods from 8/6/24 - 6/16/25. A review of the facility's policy and procedure titled, Consent, with a revision date of 2/20/25, showed: Policy: . Valid consent is therefore central to health care. Residents have the right to be given clear and transparent information, including risks and benefits associated with treatment options. They have the right to accept or refuse; it is a continuous process; therefore, a person has the right to change their mind. Procedure: 1. Informed consent occurs when clear communication is provided outlining the risks, benefits, and alternatives to a procedure, medication, or care intervention. Informed consent may be identified on a tool, in a progress note, or anywhere in the resident record . 7. Notifications/updates in resident care/condition are made to providers, residents, resident advocates, etc. and are noted within the resident record .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review, the facility failed to implement care planned fall interventions contributing to falls for 2 (#s 6 and 12) of 15 sampled residents. This deficient practice increased the risk for falls. Findings include: 1. Resident #6 Review of resident #6's Care Plan Report, date initiated 12/1/23, reflected the following: .Goal: She will be free of fall related injuries . Environmental: Provide non-skid strips on floor next to bed on both sides of bed . [sic] During an observation on 6/2/25 at 1:25 p.m., non-skid strips were not visible on the floor of resident #6's room. During an observation on 6/4/25 at 8:44 a.m., non-skid strips were not visible on the floor of resident #6's room. During an interview on 6/4/25 at 11:52 a.m., staff member K stated resident #6 did not routinely call for help and stated, I think there are strips on the floor by her bed, but no fall mat. During an observation on 6/5/25 at 8:36 a.m., non-skid strips were noted on the floor of resident #6's room. The bed was positioned near the window thus revealing non-skid strips which were not previously observed on 6/2/25 and 6/4/25. With the bed centrally positioned during previous observations in resident #6's room, the non-skid strips were hidden under the bed. Review of resident #6's electronic medical record reflected the following fall investigation root causes and changes made in care planned fall prevention interventions: 4/1/25 Unwitnessed fall in resident's room with no injury; Improper footwear noted; use of a tab alarm when in bed and wheelchair were added to the care plan on 4/6/25. No additional fall prevention interventions were added to the care plan. 5/4/25 Witnessed fall in resident's room with no injury; staff educated on locking wheelchair; no additional fall prevention interventions added to the care plan. 5/8/25 Unwitnessed fall in resident's room with major injury including multiple fractured ribs, bruising of the right hip, laceration to face, skin tear to right wrist, and bleeding into sclera of right eye; no documentation regarding whether tab alarm was activated at time of fall. No additional fall prevention interventions were added to the care plan. 2. Resident #12 Review of resident #12's Care Plan Report, date initiated 10/19/23, reflected the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Goal: I will be free of fall related injuries . Fall mat placed to prevent injury if rolling out of bed .Place in my room to remind me to call for help . Increased visual checks to ensure non-skids footwear is on . [sic] During an observation on 6/2/25 at 2:17 p.m., resident #12 was in bed, awake, the call bell and bed controls were out of her reach, sitting in the top drawer of the bedside table. There was no floor mat noted in the room. During an observation on 6/3/25 at 2:29 p.m., resident #12 was in bed, awake, with no floor mat noted in the room. There were no non-skid socks on resident #12's feet, and there was no signage posted reminding resident #12 to call for help. During an interview on 6/3/25 at 2:50 p.m., staff member L stated she was not aware of a floor mat or posted signage reminding resident #12 to call for help as part of the care planned fall prevention interventions. Staff member L stated the only fall prevention interventions she was aware of for resident #12 was Keeping her bed low, and a raised mattress, that's it. During an interview on 6/3/25 at 2:54 p.m., staff member M stated she did not know resident #12's fall prevention interventions. During an interview on 6/3/25 at 2:58 p.m., staff member N stated the only fall prevention interventions he could think of for resident #12 was a perimeter mattress. During an interview on 6/3/25 at 2:59 p.m., staff member O stated she was not aware of a fall mat or posted signage reminding resident #12 to call for help as part of the care planned fall prevention interventions. During an interview on 6/3/25 at 3:02 p.m., staff member P stated she was not aware of a fall mat or of signage reminding resident #12 to call for help as part of her fall prevention interventions. During an observation on 6/4/25 at 8:52 a.m., resident #12 was not in the room; a floor mat was noted next to the bed. During an interview on 6/4/25 at 2:39 p.m., staff member B stated her expectations for making sure new fall prevention interventions were implemented was, I would expect the CNAs to know them and do them. Staff member B stated she puts new fall prevention interventions on the communication board and Kardex which was the CNAs plan of care, and RNs sign off that they were implemented. Review of resident #12's electronic medical record reflected fall investigation reports on 2/7/25 and 5/3/25. The only new fall prevention intervention initiated on 2/10/25 was making sure resident #12 wore her CPAP at night, and on 5/8/23 a fall mat. Review of a facility document titled, Accidents and Supervision to Prevent Accidents, with a revision date of 10/15/22, reflected the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents .Implement interventions to reduce hazard(s) and risks(s) .Implementing specific interventions as part of the plan of care . Ensuring that interventions are implemented correctly and consistently .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to change oxygen tubing as ordered and keep oxygen tubing off the floor for 1 (#6) of 15 sampled residents. This deficient practice increased the risk for a respiratory infection. Findings include: During an observation on 6/2/25 at 1:25 p.m., oxygen tubing was at resident #6's bedside, and it was not dated. During an observation on 6/3/25 at 11:45 a.m., oxygen tubing was at resident #6's bedside; it was not dated, and the portion of the tubing that connects to the resident's face/nose was sitting on the floor. During an interview on 6/4/25 at 11:52 a.m., staff member K stated oxygen tubing should be changed every Tuesday or Wednesday by staff member I. During an interview on 6/4/25 at 11:57 a.m., staff member E stated oxygen tubing should be changed every Monday. During an interview on 6/4/25 at 12:02 p.m., staff member I stated she changed oxygen tubing every Monday afternoon for residents, unless she was not working, and in that case a nurse would change the tubing. During an interview on 6/4/25 at 2:39 p.m., staff member B stated oxygen tubing changes were supposed to be done once a week by staff member I. Review of the facility's policy titled, Respiratory Care, not dated, reflected the following: .The resident is provided the necessary medical and nursing care and treatment services consistent with professional standards of practice .Services include but are not limited to .Oxygen . .Procedure .5. Based on the type of respiratory care and services provided, may include, but are not limited to: .a. Oxygen services, including the safe handling .cleaning, storage .of oxygen; .k. Infection control measures during implementation of care, handling, cleaning, storage and disposal of equipment, supplies .

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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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on interview and record review, the facility failed to ensure they employed qualified and competent staff to provide social work services. This deficient practice had the potential to affect all residents in need of social services. Findings include: During an interview on 6/4/25 at 10:05 a.m., staff member A stated NF3 was originally hired as a business office assistant. She was later promoted to social service director. He stated she had some on-the-job training when she first assumed the role. Stating she went to another corporate facility and received on-site training there with the social worker at that facility. A request submitted on 6/4/25 at 10:30 a.m., for additional training/education for NF3, for acting as a social work director, was submitted. No additional training or education for NF3, related to social work services, was provided by the end of the survey. During an interview on 6/4/25 at 2:40 p.m., NF3 stated she was not originally hired as the facility's social worker. She stated she was later promoted into the position. NF3 stated she did not have a background or education in social work or a related field. She stated the only training for the position she was provided was a day spent at another facility learning how to complete the care plan conferences. She stated she was not provided any further training by the facility or additional supervised on-the-job training for the position. Review of NF3's Personnel File, showed a hire date of 8/29/23, as the assistant business office manager. Promotion to social service manager on 10/13/24, and termination date of 5/5/25. Review of NF3's Work Experience did not show previous experience or education in human services or a related field. Review of NF3's facility Relias training transcripts from, 8/30/23 to 4/9/25, did not show additional education for social services. A review of the facility's Position Description for Social Services Manager, showed, Position Summary: The responsibility of the Social Services Manager is to act as an advocate for the residents. The Social Services Manager protects vulnerable residents and ensure that their best interest is observed and helps them to find remedies to their situation . A review of the facility's policy and procedure titled, Social Services, with a release date of 11/28/17, showed, Policy: Medically related social services are provided in order to attain or maintain the highest practicable physical, mental, and psychosocial well being of the resident. Definitions: Medically-related social services means services provided by the facility's staff to assist residents in attaining or maintaining their mental and psychosocial health .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure safeguards to prevent unauthorized use of electronic signatures for residents Medicare Secondary Payer (MSP) Form for 3 (#s 9, 31, and 40) of 15 sampled residents. This deficient practice had the potential to affect all residents with the need to sign MSP forms. Findings include: During an interview on 6/4/25 at 10:05 a.m., staff member A stated it was brought to his attention that NF3 was electronically signing resident and/or resident's representative names on documents for MSP forms. He stated staff member G noticed a bunch of MSP forms being printed back-to-back for several residents. Staff member A stated when staff member G brought the concern to his attention it was noted that the documents, which had an electronic signature, were not actually signed by the residents or their representatives. During an interview on 6/4/25 at 2:46 p.m., staff member G stated NF3 was behind on getting the MSP forms signed by the residents or their representatives. She stated one morning she noticed there were several MSP forms which printed that showed the forms were signed within minutes of each other. She stated many of these forms would need authorization by the resident or their representative, and it would not be feasible to obtain those signatures in such a short period of time. Staff member G stated a resident's representative had called the office later in the day, and she had asked them about signing the MSP form. She stated the resident's representative confirmed they were not aware what the MSP form was and had not signed or given NF3 authorization to sign the form. Staff member G stated she recalled resident #s 9, 31, and 40, were affected by the unauthorized use of electronic signatures by NF3. During an interview on 6/4/25 at 2:40 p.m., NF3 stated she did electronically sign several residents' MSP forms in an attempt to get caught up. During an interview on 6/4/25 at 3:46 p.m., staff member G stated she received a list of residents who had an electronically signed MSP form in their EMR. She stated she contacted all the residents and or their representatives to validate if they actually signed or authorized the signing of the MSP. She stated many of the individuals contacted were not aware of what the MSP form was and had not authorized or signed the form. Review of resident #s 9, 31, and 40's MSP forms, and the facility's Investigation of E-Signed MSP forms validation document, showed the residents or their representatives did not authorize the signing of the MSP forms. A review of the facility's policy and procedure titled, Electronic Signatures, with a revision date of 10/15/22, showed, In an electronic medical record, the use of a unique [identification] and password and/or identification number is equivalent to an electronic signature. Only authorized persons employed or contracted by the facility for the purposes of resident care, treatment, service, or review of same, are allowed sign-on access to the electronic record. Components: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The Electronic Medical Records Access Authorization and Security Agreement is read and signed by those users designated as authorized, prior to being granted authorized access. Users are expected to adhere to the terms of the Agreement . A review of the facility's policy and procedure titled, Safeguards for Electronic Protected Health Information, with a release date of 11/28/17, showed: Policy: [Facility Name] computer-based protected health information (PHI) is safeguarded against theft, destruction and/or unauthorized disclosure through access controls . 11. The electronic format for medical or other resident documentation (for example, documenting progress notes, medication administration, electronic claims filing, etc.) complies with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules .