STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275104	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Pines Rehabilitation and Nursing	707 3rd St SE Cut Bank, MT 59427

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41652 Based on interview and record review, the facility failed to provide the required SNF ABN, Form CMS-10055 to 2 (#11 and #15) of 3 sampled residents who received Medicare Part A skilled services, and it was found the facilit had not been completing them at all for any resident. Findings include: During an interview on 11/19/24 at 4:27 p.m., staff member B stated the facility had not been completing the SNF ABN Form CMS-10055 when resident's were discharged from skilled care services. Staff member B was not able to explain why the notice was not being completed. Review of resident #11's SNF Beneficiary Protection Notification Review showed the start date for Medicare Part A skilled services was 5/23/24, with the last covered day of 7/17/24. The facility was not able to provide evidence the SNF ABN was completed. Review of resident #15's SNF Beneficiary Protection Notification Review showed the start date for Medicare Part A skilled services was 5/24/24, with the last covered day of 6/11/24. The facility was not able to provide evidence the SNF ABN was completed.

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 - Some	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. 48261 Based on observation, interview, and record review, the facility failed to develop and implement a facility policy which contained the name and contact information for the grievance official; failed to provide forms within reach of residents who were unable to stand to reach the grievance forms; and failed to provide residents with the option to file grievances anonymously, for 4 (#s 15, 22, 25, and 32) of 18 sampled residents. Findings include: During an interview on 11/19/24 at 7:57 a.m., resident #25 stated he was upset the facility management had not ordered his electric wheelchair. Resident #25 stated he was concerned the staff would be mad if he filed a complaint about them. Resident #25 stated he did not know how to file a grievance anonymously. During an interview on 11/19/24 at 3:24 p.m., resident #22 stated the resident council met monthly, and he would complete the grievance forms on behalf of the resident council, for any concerns brought forward at the meeting. Resident #22 stated the facility provided grievance forms near the nurse's station, but there was not a way to file a grievance anonymously. During an interview on 11/19/24 at 3:25 p.m., resident #15 stated the facility did not provide a way for residents to file grievances anonymously. Resident #15 stated she would like to file anonymously but did not know where to get a form. During an interview on 11/19/24 at 3:26 p.m., resident #32 stated the facility did not provide a way for residents to file grievances anonymously. During an observation and interview on 11/20/24 at 3:03 p.m., staff member C stated the facility did not have a way for residents to file a grievance anonymously or have a box for residents to place grievances in anonymously. Staff member C stated residents would need to give grievances to the staff to be turned into a supervisor or social services. Staff member C stated the only two places to obtain a grievance form were the beginning of each hall near the nurse's station. The yellow grievance forms were in a wall-mounted letter hanger, at standing shoulder level height. The forms were not reachable by a resident in a wheelchair. During the walkthrough with staff member C, grievance return boxes were not found on any facility unit. Review of a facility policy titled, Filing Grievances/Complaints, dated April 2008, showed, . 3.Residents or the resident representative also has the right to file a grievance anonymously. The policy failed to include the name and contact information for the grievance official.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41652 Based on interview and record review, the facility failed to protect residents from verbal and physical abuse by other residents for 2 (#1 and #11) of 18 sampled residents. During the survey, it was found the facility had previously identified, investigated, and corrected the non-compliance for the abuse between resident #1 and resident #11. Findings include: Review of a Facility-Reported Incident, submitted to the State Survey Agency on 10/14/24, showed resident #s 1 and 11 were involved in an incident on 9/14/24. The incident was documented in the EHR, but not identified as potential abuse until several weeks later when staff member P did an audit of resident progress notes and identified the interaction as potential abuse. Review of a second Facility-Reported Incident, submitted to the State Survey Agency on 10/15/24, showed residents #s 1 and 11 were involved in another incident on 9/17/24 which was also not identified as potential abuse. During an interview on 11/19/24 at 9:07 a.m., resident #1 denied having any issues with any other residents. During an interview on 11/20/24 at 10:08 a.m., staff members A and B were interviewed regarding the facility's processes for identifying, reporting, and investigating allegations of abuse. Staff member B stated the IDT reviewed all progress notes daily, except on weekends. He stated this was how the facility identified any concerning resident care or safety issues. Staff member B stated the IDT reviewed the 9/14/24 and 9/17/24 progress notes for residents #1 and #11. The IDT did not identify the incidents as potential abuse. Staff member B stated this was the reason for not completing the required reporting and investigation. Review of the investigative documents involving the incidents between resident #1 and resident #11 showed staff member E attempted to talk to resident #1, on 9/16/24, regarding the incident and the resident ignored her. Staff member E also talked to resident #11 who said they (resident #1 and resident #11) got their wheelchairs hooked together when resident #11 was trying to go out the main entrance door, resulting in a verbal altercation. After a discussion with IDT, it was decided this was not abuse and did not need to be reported. The second incident occurred on 9/17/24. The investigative documents showed resident #1, while in his wheelchair, went behind resident #11 and kicked the rubber bumper on resident #11's motorized wheelchair. Upon review of the resident's progress notes by IDT and interviews with the witnesses, the IDT did not identify the incident as possible abuse. Review of the facility document titled, Abuse Policy, dated 6/11/24, showed, . 1. The facility will ensure that all alleged violations involving abuse, neglect . are reported immediately, but no later than 2 hours, after the allegation is made . 2. All employees of this facility must immediately report any suspected, observed or reported incidents of resident abuse, neglect . Corrective Measures (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During EHR audits by staff member P, it was identified the two incidents between resident #1 and resident #11, which occurred on 9/14/24 and 9/17/24, were identified as abuse. Staff member P notified staff member B, the abuse coordinator, of the need to investigate and report both incidents. During an interview on 11/20/24 at 10:08 a.m., staff member A stated he identified the need for additional training for staff regarding the identification and reporting of suspected abuse. Staff member A stated staff member P audited all resident progress notes and identified the incidents between resident #1 and resident #11 as possible abuse, which should have been investigated and reported. Staff member A stated the IDT was given education on abuse identification and reporting on 10/10/24. Review of the facility document titled, Employee Education and Inservice Form, dated 10/10/24, showed the members of the IDT received education regarding the identification, investigation, and reporting of abuse allegations. Review of the minutes from the QAPI meeting, dated 10/10/24, showed the committee discussed the abuse identification and reporting issue and planned staff education for the next all staff meeting (scheduled 10/23/24). Review of the minutes from the facility all staff meeting, dated 10/23/24, showed the rest of the staff were provided education regarding the identification, investigation, and reporting of allegations of abuse between residents. Staff member P continued to audit resident progress notes to ensure no incidents of possible abuse were missed. The corrective action for the deficient practice was completed on 10/23/24, with ongoing monitoring by staff member P.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41652 Based on interview and record review, the facility failed to report allegations of abuse to the State Survey Agency within 24 hours of the incident for 2 (#s 1 and 11); and failed to submit the results of an investigation within 5 working days for 1 (#12) of 18 sampled residents. Findings include: 1. Review of a Facility-Reported Incident, submitted to the State Survey Agency on 10/14/24, showed resident #s 1 and 11 were involved in an incident on 9/14/24. The incident was documented in the EHR but not identified as potential abuse until 10/14/24, when the abuse allegation was reported on the State's reporting portal. The incident was identified as an abuse allegation when staff member P did an audit of resident progress notes and identified the interaction as potential abuse. Review of a second Facility-Reported Incident, submitted to the State Survey Agency on 10/15/24, showed residents #s 1 and 11 were involved in another incident on 9/17/24, which was not initially identified as potential abuse. The incident was identified as an abuse allegation when staff member P did an audit of resident progress notes and identified the interaction as potential abuse. During an interview on 11/20/24 at 10:08 a.m., staff members A and B were interviewed regarding the facility's processes for identifying, reporting, and investigating allegations of abuse. Staff member B stated the IDT reviewed all progress notes daily, except on weekends. He stated this was how the facility identified any concerning resident care or safety issues. Staff member B stated the IDT reviewed the 9/14/24 and 9/17/24 progress notes for resident #1 and resident #11. The IDT did not identify the incidents as potential abuse. Staff member B stated this was the reason for not completing the required reporting in a timely manner. Staff member A stated he identified the need for additional training for staff regarding the identification and reporting of suspected abuse. Staff member A stated staff member P audited all resident progress notes and identified the incidents between resident #1 and resident #11 (9/14/24 and 9/17/24) as possible abuse, which should have been investigated and reported to the State Survey Agency within 24 hours of the incident. Review of the investigative documents involving the incidents between resident #1 and resident #11 showed staff member E attempted to talk to resident #1, on 9/16/24, regarding the incident, and the resident ignored her. Staff member E also talked to resident #11 who said they (resident #1 and resident #11) got their wheelchairs hooked together when resident #11 was trying to go out the main entrance door, resulting in a verbal altercation. After a discussion with IDT, it was decided this was not abuse and did not need to be reported. The second incident occurred on 9/17/24. The documents showed resident #1, while in his wheelchair, went behind resident #11 and kicked the rubber bumper on resident #11's motorized wheelchair. Upon initial review of the resident's progress notes and interviews with the witnesses, the IDT did not identify the incident on 9/17/24 as possible abuse, although #1 acted purposefully. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled, Abuse Policy, dated 6/11/24, showed, The facility will ensure that all alleged violations involving abuse, neglect . are reported immediately, but no 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 administration of the facility . [sic] 2. Review of a Facility-Reported Incident, submitted to the State Survey Agency on 9/17/24 showed resident #12 had reported two CNAs were rough during her cares approximately two weeks prior. The results of the investigation were due to be submitted by 9/24/24, and were not submitted until 9/26/24. During an interview on 11/20/24 at 10:08 a.m., staff members A and B were interviewed regarding the submission of abuse allegations. Staff member B stated he was aware of the five day time limit for submitting results of the investigation. Staff member B stated he had been having trouble with the reporting portal and needed more training with it. Staff member B stated he missed the deadline because of his lack of knowledge of how the portal worked. Review of the facility document titled, Abuse Policy, dated 6/11/24, showed, The Administrator or designee shall report the results of all investigations to the State Survey Agency within 5 working days of the incident .

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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. 41652 Based on interview and record review, the facility failed to complete accurate MDS coding for 2 (#s 19 and 24) of 18 sampled residents. Findings include: 1. During an observation and interview on 11/18/24 at 4:22 p.m., resident #19 said he was hospitalized earlier this year for a psychiatric evaluation. Resident #19 stated he had mental health problems and took medications for them. Review of resident #19's physician orders, dated 6/24/24, showed an order for aripiprazole, 5 mg at bedtime, related to a diagnosis of major depressive disorder, recurrent severe without psychotic features. Review of resident #19's MAR, dated July of 2024, showed the resident was receiving the anti-psychotic medication aripiprazole 5 mg at bedtime for the entire month of July 2024. Review of resident #19's Annual MDS, with an ARD of 7/7/24, failed to show the resident was receiving an anti-psychotic medication (aripiprazole) daily during the observation period. The nurse who completed the MDS was no longer employed by the facility, and the reason for the coding error could not be determined. Review of resident #19's physician orders, dated 9/27/24, showed the resident was receiving aripiprazole 10 mg at bedtime related to a diagnosis of major depressive disorder, recurrent severe without psychotic features. Review of resident #19's MAR, dated September of 2024, showed the resident was receiving the anti-psychotic medication aripiprazole 10 mg at bedtime from 9/27/24 through 9/30/24. Review of resident #19's MAR, dated October of 2024, showed the resident was receiving the anti-psychotic medication aripiprazole 10 mg at bedtime from 10/1/24 through 10/8/24. Review of resident #19's Quarterly MDS, with an ARD of 10/1/24, failed to show the resident was receiving an anti-psychotic medication (aripiprazole) on at least four days during the observation period. The nurse who completed the MDS was no longer employed by the facility, and the reason for the coding error could not be determined. 48261 2. During an interview on 11/19/24 at 11:10 a.m., resident #24 stated she had not been on antibiotics as far as she knew. Review of resident #24's MDS 3.0 Section N-Medications, with an ARD date of 9/1/24, reflected resident #24 was on an antibiotic. The MDS section was signed on September 16, 2024, at 8:48 a.m. Review of resident #24's EHR physician orders, dated 5/26/24 - 11/17/24, reflected no antibiotics ordered. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #24's September 2024 MAR, dated 9/1/24 - 9/30/24, reflected no antibiotics were administered to resident #24.

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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. 48268 Based on interview and record review, the facility failed to revise an individualize comprehensive care plan to reflect the current management and interventions for a mental health diagnosis, for 1 (#30) of 18 sampled residents. Findings include: During an interview on 11/19/24 at 9:33 a.m., resident #30 stated she had, . a lot of anxiety and worry. Resident #30 stated, I have always been a worrier, for no good reason I suppose. During an interview on 11/20/24, staff member L was unable to state what non-pharmacological interventions were tried to help resident #30 with her anxiety. Review of resident #30's EHR showed resident #30 was taking alprazolam, sertraline, and quetiapine for the treatment of her anxiety. Review of resident #30's care plan, initiated on 6/19/24, with the latest update on 11/18/24, failed to show anxiety as a focus area, failed to show non-pharmacological interventions for the management of her anxiety, and failed to show the pharmacological treatments and potential side effects.

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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. 48268 Based on observation, interview, and record review, the facility failed to meet professional standards of practice by administering insulin by pen without first priming the pen. This deficient practice caused the resident to receive 2 units less insulin than prescribed and had the potential to cause an elevated blood glucose for 1 (#19) of 18 sampled residents. Findings include: During an observation and interview on 11/19/24 at 9:25 a.m., staff member H, who was orienting staff member N, was observed attaching a needle to an insulin detemir pen, 100 U/mL, and administering 10 units to resident #19 without first priming the pen with 2 units of the insulin. Staff member N stated she believed priming of insulin pens was considered standard practice and did observe staff member H not priming the pen prior to administering the prescribed dose of insulin. During an interview on 11/21/24 at 11:12 a.m., staff member C stated the priming of insulin pens was the expectation of all nurses prior to the administration of insulin and was considered standard practice, as per manufacturer's instructions. A review of manufacturer instructions for the use of insulin detemir injection pen, revised 12/2022, showed industry standard instructions for priming the insulin pen prior to each use by using a two-unit setting, holding the pen upright, releasing the pen trigger, followed by ensuring a drop of insulin was visible on the tip of the needle before administering the required dose.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 48268 Based on interview and record review, the facility failed to complete a discharge summary which included a recapitulation of the resident's stay, and a post-discharge plan of care, for 1 (#34) of 2 residents sampled for a closed record review. Findings include: During an interview on 11/21/24 at 7:50 a.m., staff member G stated the nurses were responsible for the discharge summary at the time of a resident discharge. During an interview and record review on 11/21/24 at 2:25 p.m., staff member C stated the nurse discharging the resident would be responsible for the discharge summary. Review of resident #34's EHR failed to show any documentation of a recapitulation of the resident's stay, or a post-discharge plan of care, completed by nursing or the resident's physician. A document request was made on 11/19/24 at 3:30 p.m. for resident #34's discharge summary and recapitulation of stay. No additional documentation was received by the end of the survey.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on observation, interview, and record review, the facility failed to prevent Immediate Jeopardy level accidents and hazards by failing to effectively use a fall prevention program, root cause analysis, identify and implement appropriate interventions, and ensure staff used the interventions appropriately, for 3 (#s 7, 25, and 27) of 17 sampled residents. The on-going failure led to resident #25 sustaining a head laceration, requiring staples and an overnight stay in the hospital; resident #7 sustaining a head laceration requiring staples, a hip hematoma, and bruising on the left temple; and resident #27 sustaining a hematoma above the left eye and bloody nose. On 11/20/24 at 4:30 p.m., the facility Administrator and administrative staff were notified of an Immediate Jeopardy involving resident #25, pertaining to F689 - Free of Accident Hazards/supervision/devices. The facility provided an acceptable plan to remove the immediacy for the resident involved, and the time the immediacy was removed was at 12:00 p.m. on 11/21/24. The surveyors were onsite and verified the removal of immediacy by observations, interviews, and record reviews. The Severity and Scope of the Immediate Jeopardy was identified to be at the level of J, and upon removal of immediacy, lowered to H. Findings include: 1. During an observation and interview on 11/19/24 at 7:54 a.m., resident #25 stated he . had a fall and busted my head open, and had to get five staples. Resident #25 stated he fell in the bathroom. Resident #25 had black slip resistant tape on the floor in the bathroom, next to his bed, and in front of his lift recliner. Resident #25 stated his lift recliner was broken and had not worked over the past month. Resident #25 stated his reacher tool was on the other side of the room somewhere, but he did not know where. During an interview on 11/20/24 at 9:54 a.m., staff member M stated the interventions for resident #25 were grip tape on the floors, grip socks, and to provide call light education. Staff member M stated resident #25's recliner chair had been broken for at least two weeks. Staff member M stated she had reported the broken lift recliner to staff member C at least two weeks prior. Staff member M stated there were no other fall interventions for resident #25, and she was not aware of a toileting program for resident #25. During an interview on 11/20/24 at 10:11 a.m., staff member K stated she had been saying the lift recliner had only been working off and on for the past month. Staff member K reported the broken chair to staff member C. Staff member K stated she did not know resident #25 was on a toileting program. Staff member K stated resident #25 toileted himself. Review of resident #25's EHR reflected resident #25 was admitted to the facility on [DATE]. Review of resident #25's Fall documentation, dated 5/15/24 - 10/24/24, reflected: - Resident #25 fell on [DATE]. The nurse reported resident #25 stated he fell off the chair while attempting to change his clothes. No IDT notes were available per staff member C. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident #25 fell on [DATE], after walking from the bathroom to his chair. Resident #25 slid off the chair while attempting to sit. No nurses' notes or IDT notes were available per staff member C. - Resident #25 fell on [DATE] while walking from the bathroom to his chair. No IDT notes were available per staff member C. - Resident #25 fell on [DATE] while in the bathroom, toileting himself. No IDT notes were available per staff member C. - Resident #25 fell on [DATE] while attempting to get out of bed and urinated prior to reaching the bathroom or having assistance. Non-skid socks were the intervention listed after the fall. No IDT notes were available per staff member C. - Resident #25 fell on [DATE] while in the bathroom. Resident #25 stated the toilet riser was not bolted down and it slid off the toilet. IDT interventions listed included a lift recliner and toilet riser that would bolt down. - Resident #25 fell on [DATE] while in the shower room with the CNA. Resident #25 attempted to sit when no chair was behind him and fell to the floor. The IDT re-educated the CNA on placing a chair behind the resident before the resident sat down. - Resident #25 fell on [DATE] while in the bathroom. Resident #25 stated he was changing his underwear when he became dizzy and fell . Resident #25 stated he was trying to stand up and could not grip the floor. This fall resulted in a head laceration, requiring five staples in the emergency room , and an overnight stay in the hospital for observation and tests. IDT interventions listed included a room move closer to the nurse's station, a toileting program which would prompt him to attempt to toilet at least every few hours, and he agreed to push the call light when he needed to use the restroom. - Resident #25 fell twice on 9/27/24, once at 3:25 a.m. and again at 12:54 p.m. while in the bathroom. The nurse reported the resident #25 stated the floor was too slick. The nurse reported the non-skid strips had not yet been placed in the resident's new room. Resident #25 changed rooms on 9/24/24 for closer observation. IDT interventions listed included replacing the non-skid strips to floor in the bathroom, and the resident's room was rearranged to move his lift recliner closer to the bathroom. The IDT note of investigation was dated 10/24/24 for the second fall on 9/27/24. - Resident #25 fell on [DATE] while attempting to get from his lift chair to his bed. Resident #25 stated his legs gave out. IDT interventions listed included preventative measures that were in his previous room were put in place in new room, re-educated on call light use, wearing non-skid socks, and use his hemi-walker. - Resident #25 fell on [DATE] while getting his clothes from the closet resulting in an abrasion to his left shoulder, and a small laceration to his left elbow. IDT interventions listed included re-educating the resident on call light use, wearing non-skid socks, and to use his hemi-walker. Review of resident #25's Fall risk assessment, dated 5/4/24 - 10/18/24, reflected resident #25 was at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #25's care plan, dated 5/4/24 - 11/20/24, reflected the following interventions: - Resident #25 was at risk for falls related to left-sided weakness, - Call light needed to be within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance with a date initiated of 5/14/24, - Resident #25 required an unknown amount of assistance with bed mobility and bathing/showering, toileting use, transfers, and eating. The ADL care plan, initiated on 10/25/24, had a standardized template and was not completed with resident-specific information, - Resident #25 required a sit-to-stand recliner for rising assistance with a date initiated of 9/18/24, - Resident #25 was to have set interval toileting and/or continence programs; providing easy access to urinals and bedpans with a date initiated of 10/25/24, and - Resident #25 was to have a reacher tool for assistance with picking items up from the floor with a date initiated of 7/8/24. Review of a hand-written facility document, dated 9/24/24, in the CNA communication log, was a note that reflected: - . We are also implementing a toileting program for him. Every 2 hours ask him to use the bathroom and standby if he needs assistance. We are attempting to prevent further falls. He agreed to the above plan. During an interview on 11/20/24 at 5:31 p.m., staff member F stated resident #25 was stubborn, and he should be on a toileting program since he didn't use his call light and could not use the urinal successfully. Staff member F stated, He's (resident #25) a bit of a sticky-wicket, but we should be trying everything we can to prevent the falls. 2. During an observation on 11/19/24 at 8:27 a.m., resident #7 was in her room, in a wheelchair. The call light was on the floor, but under her bed. There were two large black trash bags on floor in her room. Resident #7 was getting up from her wheelchair and using furniture to attempt to walk in her room. The space was very tight, between the end of the bed and the wall, and the wheelchair would not fit to reach her belongings on the far side of her bed. Resident #7 attempted to maneuver her wheelchair around the walker, a chair, and black bags on the floor, but she became stuck between the end of the bed and the wall. Resident #7 was sitting in the wheelchair with blankets piled on her lap, and unable to move her wheelchair. Resident #7 was calling out for help. Facility staff did not hear resident #7 calling out. This surveyor notified staff member N that the resident was calling for help and unable to reach a call light. Staff member N assisted resident #7 to free her wheelchair. Review of resident #7's EHR reflected resident #7 was admitted to the facility on [DATE]. Review of resident #7's fall investigations, dated 11/22/23 - 8/14/24, reflected: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident #7 fell on [DATE]. The nurse reported resident #7 stated she slid off the bed while putting on her pants. No IDT notes were available, per staff member C. - Resident #7 fell on [DATE] while getting her clothing, resulting in a head laceration requiring five staples in the emergency room , a hip hematoma, and bruising on the left temple. No IDT notes were available, per staff member C. Review of resident #7's BIMS assessment(s), dated 2/22/24 - 8/27/24, reflected resident #7 had severe cognitive impairment. Review of resident #7's Fall Risk Assessment(s), dated 8/30/23 - 10/18/24, reflected resident #7 was at moderate to high risk of falls. Review of resident #7's care plan, dated 3/13/23 - 11/20/24, reflected: - Resident #7 was at high risk for falls related to incontinence, gait balance, and weakness, - Call light needed to be within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, - Resident #7 required limited to extensive assistance of one person with bed mobility, transfers, and ambulation, - Resident #7's care plan did not include a comprehensive fall care plan until after resident #7's second fall on 12/17/23, - Resident #7's care plan did not include any interventions related to dressing assistance. 3. During an observation and interview on 11/19/24 at 10:04 a.m., resident #27 stated he had a fall where he slid off the mattress resulting in a knot above his eye and a bloody nose. Resident #27 stated he slid out of wheelchair on another occasion. Resident #27's call light was clipped to the wall above his bed, out of reach. Resident #27 was sitting in his wheelchair in his room. Resident #27 stated he did not know where his reacher tool was located. Review of resident #27's EHR reflected resident #27 was admitted to the facility on [DATE]. Review of resident #27's fall investigations, dated 2/1/24 - 5/13/24, reflected: - Resident #27 fell on [DATE] while attempting to pick up papers he dropped on the floor. No IDT notes were available per staff member C. - Resident #27 fell on [DATE] having slid out of his wheelchair. No IDT notes were available per staff member C. - Resident #27 fell on [DATE] with resident #27 found on the floor. The floor and bed both soaked in urine and the bed mattress sliding off the frame. This fall resulted in a hematoma above the left eye and a bloody nose. No IDT notes were available per staff member C. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Resident #27 fell on [DATE] having fallen asleep and slid out of his wheelchair. No IDT notes were available per staff member C. - Resident #27 fell on [DATE] when he attempted to pick up the remote from the floor and tipped over his wheelchair. No IDT notes were available per staff member C. - Resident #27 fell on [DATE] when he attempted to pull up his pants in the bathroom. The IDT team interventions listed resident education to use the call light, resident to be placed in bed when in his room. Review of resident #27's care plan, dated 2/2/24 - 11/20/24, reflected the following interventions: - Resident #27 required an unknown amount of assistance with bed mobility, bathing/showering, dressing, personal hygiene, toileting use, transfers, and eating. The ADL care plan, initiated on 2/26/24, had a standardized template which was not completed with resident-specific information, - Resident #27 was to be oriented to the call light, the call light was to be kept within reach, and staff were to encourage him to use it for assistance as needed, and this was initiated on 2/26/24, - Resident #27 was to have a reacher tool available to pick up items off the floor with a date initiated of 3/4/24. During an interview on 11/20/24 at 10:16 a.m., with staff members B and C, staff member C stated she did not know why toileting and getting his clothing out were not considered earlier with resident #25's falls, and the IDT was trying to figure out their (fall investigation) processes. Staff member C stated resident #25 did not use his call light, and the IDT was waiting for the regional support team to train the IDT related to fall investigations and interventions. Staff member B stated the facility was supposed to have training in April 2024, but the regional support person was pulled to another facility, so the training occurred in October 2024. Staff member B and C both reported they could not speak to falls prior to May 2024, because they were not in the facility at that time. Staff member B stated they recognized the facility had an issue with care plans and falls and started a PIP but were waiting for the regional support training to start the PIP. Staff member C stated she was aware the lift chair was having problems but thought the chair had been fixed. Staff member C stated she was not aware the CNAs or nurses were not aware of the toileting program or offering resident #25 toileting assistance every two hours. Review of the facility document titled, Incidents by Type Fall Report, dated 11/18/23 - 11/18/24, reflected a total of 188 falls. Of the 188 total falls, 21 residents accounted for 150 falls or 79% of the total falls. Review of the facility's policy, Fall-Clinical Protocol, dated September 2012, reflected: - . 3. For an individual who has fallen, the interdisciplinary team will complete an evaluation to identify the root cause and recommend appropriate new interventions to address risk factors of falling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- . 8. If the individual continues to fall, the staff will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48268 Based on interview and record review, the facility failed to ensure residents did not receive medication without an adequate indication for its use for 1 (#30) of 5 residents reviewed for unnecessary medications. Findings include: Review of resident #30's EHR progress notes showed resident #30 was prescribed an antibiotic, pending results of a urine culture, on 9/21/24. A urine culture result was noted to be negative for infection on 9/22/24, but the resident remained on antibiotics for a total of eight days (9/21/24 - 9/28/24) as noted on resident #30's MAR. During an interview on 11/21/24 at 2:55 p.m., staff member C stated she was unaware resident #30 had been given an antibiotic after a negative urine culture. Review of resident #30's EHR failed to show any prescriber rationale or indication for the continued course of treatment over the eight-day period.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48261 Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medications for 1 (#30); and failed to complete the gradual dose reduction for 1 (#25) of 18 sampled residents. Findings include: 1. Review of a facility, pharmacy review, dated 9/28/24, reflected resident #25 was due for a gradual dose reduction for fluoxetine 10 mg daily. Review of a faxed gradual dose reduction order for #25, dated 9/28/24, reflected the pharmacist's recommendation to discontinue the fluoxetine. The physician reply showed the physician agreed with the pharmacist's recommendation and to please implement the order. Review of resident #25's MAR, dated September, October and Novemeber 2024, reflected resident #25 continued to receive fluoxetine, 10 mg daily, until this was questioned by the surveyor on 11/21/24. During an interview on 11/20/24 at 8:39 a.m., staff member D stated the gradual dose reduction was never implemented and was being addressed that day. 48268 2. During an interview on 11/19/24 at 9:33 a.m., resident #30 stated she had, . a lot of anxiety and worry. Review of resident #30's MAR, dated October 2024, included the following medications: For anxiety: - sertraline 100 mg daily - alprazolam 0.25 mg at bedtime - quetiapine 12.5 mg twice daily For cardiovascular disease and hypertension: - metoprolol tartrate 50 mg twice daily - telmisartan 40 mg daily - amLODIPine besylate 5 mg daily - furosemide 40 mg daily (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #30's progress notes, dated 10/14/24, showed: - Resident has had increased anxiety with ADL's. Family requested something for the anxiety other than her Xanax (alprazolam). Spoke with [staff member F]. Recommended Seroquel (quetiapine) 12.5 mg PO BID. Spoke with resident about using Seroquel (quetiapine) and she is wanting to try it. Verbal consent received from [resident #30's daughter]. [sic] Review of resident #30's MAR, dated October 2024, showed resident #30 was started on quetiapine 12.5 mg twice daily, for anxiety, starting on 10/15/24. Alprazolam was not discontinued. Review of resident #30's progress notes, dated 10/16/24 through 10/24/24, after the addition of quetiapine (10/15/24), showed the following: - 10/16/24: Resident has been very weak, lethargic and low BP. Notified [staff member F]. New orders received to decrease metoprolol tartrate to 25 mg po BID . [sic] - 10/17/24: Residents BP low this AM at 98/56, pulse 72. Held all BP medications and notified [staff member F]. Resident has been alert and able to participate in therapy. Call was received back to D/C Micardis (telmisartan) at this time. Will continue to monitor BP. [sic] - 10/18/24: Resident having low BP. Received orders per [staff member F] to d/c metoprolol and Micardis (telmisartan). Continue BP BID x 7 days. Notified resident of medication changes. [sic] - 10/24/24: Email sent to [staff member F] regarding continued low blood pressures since discontinuing medications about a week ago. Blood pressures today were 95/57 and 88/51 respectively. Resident does report fatigue and dizziness. Will continue to monitor. [sic] Review of resident #30's progress notes for the period of 7/15/24 through 10/15/24 did not show concerns of low blood pressure. Review of resident #30's pharmacy medication review, dated October 2024, reflected the pharmicist requested an appropriate indication for the use of quetiapine. The recommendation showed anxiety was not an appropriate indication for quetiapine. Review of resident #30's MAR, dated November 2024, reflected resident #30 continued to receive quetiapine with an indication of anxiety. Review of resident #30's EHR failed to show adequate rationale or indication for the addition of an antipsychotic medication in an elderly resident with cardiovascular compromise, failed to show adequate monitoring of a newly prescribed antipsychotic medication. Staff member F discontinued resident #30's cardiovascular medications (Micardis and metoprolol), did not reduce or discontinue the psychotropic medications (sertraline, alprazolam, and quetiapine), and did not document consideration of potential psychotropic effect on the resident's fragile health, including hypotension. Review of a professional drug interaction report on www.drugs.com, accessed on 11/26/24, showed quetiapine added to resident #30's medication regimen increased the risk for hypotension, lethargy, dizziness, sedation, and impairment of attention, judgment, thinking, and psychomotor skills.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 48261 Based on observation, interview, and record review, the facility failed to provide dental services for 2 (#s 7 and 25) of 18 sampled residents. Findings include: 1. During an observation and interview on 11/19/24 at 8:28 a.m., resident #7 stated dental services had not been offered to her. During the interview it was observed the resident had a thick white plaque covering her teeth and a strong foul oral odor when she talked. Review of resident #7's BIMS assessment, dated 8/27/24, reflected resident #7 had a BIMS of 6, a severe cognitive impairment. Review of resident #7's care plan, dated 3/8/23-11/20/24, reflected resident #7 had top dentures and missing teeth on the bottom, with an initiated date of 11/20/23. 2. During an observation and interview on 11/19/24 at 7:50 a.m., resident #25 stated he had not been offered any dental care services at the facility or off site. Resident #25 had no dentures and many missing teeth per his report. Resident #25 stated he would like to see a dentist about his teeth. Review of resident #25's care plan, dated 5/7/24-11/20/24, reflected: - ORAL CARE ROUTINE (AM, PC, HS): SPECIFY brush teeth, rinse dentures, clean gums with toothette, rinse mouth with wash. Date Initiated: 10/25/2024. During an interview on 11/21/24 at 7:45 a.m., staff member A stated he could not locate any appointments scheduled for residents #7 or #25 in the past. Staff member A stated the facility would be working on addressing the dental needs of both residents. During an interview on 11/21/24 at 10:45 a.m., staff member D stated the facility did not have a policy specific to dental services.

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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. 48261 Based on interview and record review, the facility failed to ensure the director of food and nutrition services met the education qualifications required by CMS for a food service director, which increased the risk of residents being affected negatively since the director provided oversight for the entire dietary department. Findings include: During an interview on 11/19/24 at 12:13 p.m., staff member I stated staff member B told him to complete the first eight hour course of training and not to worry about the 16 hour training course until later. During an interview on 11/20/24 at 8:39 a.m., staff member D stated no policies specific to the dietary manager training requirements were available, and the facility used the CMS guidelines. During an interview on 11/20/24 at 9:41 a.m., staff member B stated staff member I did not have any further training in the Food Service Manager program. Staff member B stated staff member I had completed the first eight hours of the training course and did not realize he had the second part to complete. Staff member B stated no other staff in the building had completed the dietary manager certification requirements. Review of staff member I's employee file reflected staff member I was hired on 8/28/24 and had not completed the dietary manager certification training.

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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. 48261 Based on observation, interview, and record review, the facility staff failed to serve food in accordance with professional standards for food service safety, by not wearing hairnets, while in food service areas. Failure to uphold food safety may affect any resident at the facility. Findings include: During an observation on 11/18/24 at 2:51 p.m., staff member O had no hairnet on while walking through the kitchen while the cook was making meatballs. Staff member J was not wearing a hairnet while walking through the kitchen and working on stocking directly next to the prep table, where the cook was preparing meatballs. During an observation on 11/18/24 at 5:12 p.m., staff member J was prepping meal trays (for another location), and was not wearing a hairnet. She had braids hanging down past her shoulders in front. The ends of the braids hung over the food when she leaned forward. During an observation on 11/19/24 at 8:15 a.m., staff member J had braids hanging down past her shoulders, in the front, while prepping trays in the kitchen. Hair from the end of the braids was nearly touching the trays while she was bent over reaching for the other trays. During an interview on 11/19/24 at 12:13 p.m., staff member I stated all staff entering the kitchen were required to wear a hairnet covering all hair. Staff member I stated the hairnets and beard nets were kept in the top drawer of his desk, by the back door. Staff member I stated he was working to get hairnet dispensers on the other doors to the kitchen since staff from other departments enter from those doors. Review of a facility policy titled, Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, dated October 2017, reflected: - . 12. Hairnets or caps/hats and beard restraints (as indicated) must be worn to keep body hair from contacting exposed food, clean equipment, utensils, and linens.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652 Based on interview and record review, the facility administrator failed to provide adequate oversight and training for the Administrator in Training (AIT), and the DON, with regard to the responsibilities of the interdisciplinary team reviews and processes to be used, and how to conduct a performance improvement project related to the fall prevention protocol, for 3 (#s 7, 25, and 27) for 18 sampled residents; and the administrator failed to ensure the facility employed a certified Infection Preventionist, and failed to ensure the facility employed a qualified Dietary Manager which may affect any resident at the facility. Findings include: 1. Review of resident #25's EHR showed the resident sustained 12 falls between his admission on 5/2/24, and the start of the survey, on 11/18/24. The IDT did not address the first five falls sustained by the resident between 5/15/24 and 9/16/24. Resident #25 sustained a fall on 9/17/24 which necessitated an overnight hospital stay for monitoring and staples to a head laceration. The only care plan revision, other than the fall prevention interventions initiated at the time of his admission, showed the only revision to the care plan was the addition of a reacher tool on 7/8/24 and non-skid socks after a fall on 8/23/24. IDT notes between 9/17/24 and 11/18/24 failed to show an effective evaluation of the root causes of the resident's repeated falls. Review of resident #7's EHR showed the resident sustained two falls between 11/22/23 and 12/17/23, resulting in a head laceration, requiring staples and bruising to her left hip. The resident had severe cognitive impairment and was at a high risk for falls. The resident's care plan, managed by the IDT, failed to show a fall prevention plan until after the resident's third fall on 1/13/24. IDT documentation failed to show an effective evaluation of the root causes for the resident's repeated falls. Review of resident #27's EHR showed the resident was admitted to the facility on [DATE] and sustained six falls between 2/1/24 and 5/13/24. There were no IDT notes until 5/13/24. IDT documentation failed to show an effective evaluation of the root causes for the resident's repeated falls. See F689 Free OfAccidents and Hazards/supervision/devices for additional details regarding resident #s 7, 25, and 27's falls. During an interview on 11/20/24 at 10:16 a.m., with staff members B and C, staff member C stated the IDT was trying to figure out their processes, and they were waiting for regional support to provide fall prevention training. Staff member B stated the training was supposed to occur in April (2024), but did not happen until September of 2024. Staff member B stated the facility recognized they had issues with fall prevention and care plan management. During an interview on 11/21/24 at 8:22 a.m., staff member A stated the process of fall management started with a resident falling. The staff member who witnessed the fall or found the resident was responsible for reporting the incident to the nurse. The nurse did an assessment and notified the administrator and the DON. Staff member A stated the IDT was responsible for doing a root cause analysis and determining what interventions would be implemented. Staff member A stated staff member P (regional support) did education in September (2024) regarding fall management. (continued on next page)

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	275104	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Pines Rehabilitation and Nursing	707 3rd St SE Cut Bank, MT 59427

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an interview on 11/21/24 at 3:25 p.m., staff member C stated she was just beginning to learn about infection control and prevention and was not familiar with any specific antibiotic management algorithms for monitoring appropriate antibiotic use. Staff member C stated staff member F was, not following McGreer Criteria (antibiotic use protocol). Staff member C also stated the facility had difficulty obtaining urine culture results and had to call the hospital several times to obtain most laboratory test results. See F882 Infection Preventionist Qualifications/role for additional details regarding the qualifications of the Infection Preventionist. 3. During an interview on 11/20/24 at 9:41 a.m., staff member B stated staff member I did not have any further training in the Food Service Manager program. Staff member B stated staff member I had completed the first eight hours of the course and did not realize he had the second part to complete. Staff member B stated no other staff in the building had completed the dietary manager certification requirements. See F801 Qualified Dietary Staff for additional details regarding the qualifications of the Dietary Manager.

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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. 48261 Based on observation, interview, and record review, the facility failed to ensure residents were offered hand hygiene before meals in the dining room for 1 (#22) of 18 sampled residents; and failed to follow appropriate infection control practices for proper hand hygiene between resident contact for 4 (#s 2, 19, 25, and 32) of 5 sampled residents for medication administration. Findings include: 1. During an observation in the dining room on 11/19/24 at 8:06 a.m., the residents were being brought down to the dining room and set-up at tables. Residents were offered a clothing protector and offered a drink of their choice. The meal trays were then being served by staff at the kitchen window. Residents were not offered the option to clean their hands before they received their meals. During an interview on 11/19/24 at 8:16 a.m., resident #22 stated the staff did not offer hand hygiene to the residents. During an interview on 11/19/24 at 9:35 a.m., staff member K stated hand hygiene was, offered sometimes, but we forget most of the time to be honest. And it's hard to get patients up to the sink, especially if they are wheelchair bound. They don't offer another way to wash their hands in the dining room. During an interview on 11/19/24 at 12:13 p.m., staff member I stated there was nowhere except the sink for residents to perform hand hygiene before meals. During an interview on 11/20/24 at 8:39 a.m., staff member D stated the facility's policy on hand hygiene for residents was the same as the hand hygiene for staff. 48268 2. During an observation on 11/19/24, between 7:56 a.m. and 9:25 a.m., staff member H was observed for medication preparation and administration. A total of five resident medication administrations were observed. Hand hygiene was not performed between residents for four of the five medication administration observations, which were #s 2, 19, 25, and 32. During an interview on 11/21/24 at 11:12 a.m., staff member C stated hand hygiene was required by all staff before and after resident contact to prevent infection. Review of facility document titled, Handwashing/Hand Hygiene, dated August 2014, showed the following: - . 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. - 4. Residents, family members and/or visitors will be encouraged to practice hand hygiene .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 41652 48268 Based on observation, interview and record review, the facility failed to maintain an effective antibiotic stewardship program to include adequate monitoring of antibiotic use for 2 (#s 2 and 30) of 18 sampled residents. Findings include: 1. During an observation and interview on 11/19/24 at 11:52 a.m., resident #2 stated he had a suprapubic catheter and had a history of urinary infections. Resident #2 stated he had been on a number of antibiotcs in the past few months. Resident #2 stated he believed the doctor did not put him on antibiotics for enough time to treat his UTI. Resident #2 stated it took several months to get rid of the infection. Review of resident #2's physician orders, dated from 6/21/24 to 10/15/24, showed the following: - 5/7/24: Bactrim DS one tablet twice a day for seven days, - 6/21/24: clindamycin 300 mg, three times daily for 10 days for UTI, - 7/22/24: Macrobid 100 mg twice daily for 10 days for UTI, - 9/18/24: Levaquin 500 mg daily for seven days for UTI, and - 10/15/24: cefazolin 2 grams intramuscular injection daily for five days for UTI. Review of resident #2's urine culture and sensitivity results, between 5/6/24 and 10/8/24, showed the following: - 5/6/24: methacillin resistant staph aureus, sensitive to Macrobid, tetracycline, Bactrim, and vancomycin, - 6/14/24: stenotrophomonus maltophilia, sensitive to Bactrim - 7/12/24: pseudomonas seruginosa and enterococcus faecalis, sensitive to ciprofloxacin, gentamycin, imipenem, maropenem, augmentin, Macrobid, penicillin-G, tobramycin, piperacillin, and vancomycin, - 9/16/24: proteus mirabolis, sensitive to cefazolin, ceftriaxone, piperacillin, and - 10/8/24: proteus mirabolis, sensitive to cefazolin, ceftriaxone, piperacillin. No results for follow-up urine cultures were found in resident #2's EHR. Review of resident #2's medication megimen reviews, dated December 2023 through October 2024, failed to show any recommendations from the pharmicist regarding antibiobtic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview on 11/21/24 at 12:31 p.m., NF1 stated, I don't provide any input on the antibiotic use at the facility. The infection control person and the medical director there have their own program in the facility. During an interview on 11/21/24 at 3:25 p.m., staff member C stated she was just beginning to learn about infection control and prevention, and was not familiar with any specific antibiotic management algorithms for monitoring appropriate antibiotic use. Staff member C stated staff member F was, not following McGreer Criteria (antibiotic use protocol). Staff member C also stated the facility had difficulty obtaining urine culture results and had to call the hospital several times to obtain most laboratory test results. Review of resident #30's progress notes showed resident #30 was prescribed an antibiotic pending results of a urine culture on 9/21/24. The urine culture result was noted to be negative for infection on 9/22/24. Resident #30 remained on the antibiotic for a total of eight days (9/21/24 - 9/28/24) as noted on the resident's MAR. Review of a facility document titled, Infection Prevention and Control Program, adopted 12/19/2016, showed: - . 4. Antibiotic Stewardship . a. The infection preventionist is chiefly responsible to ensure that antibiotics are used consistently with best practice standards.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48268 Based on interview and record review, the facility failed to ensure the designated Infection Preventionist was qualified through an approved certification program prior to assuming the role of Infection Preventionist. The deficient practice had the potential to affect all residents receiving care in the facility. Findings include: During an interview on 11/18/24 at 3:48 p.m., staff member A stated the facility's Infection Preventionist resigned approximately one week earlier, and staff member C was in the process of taking the class. Staff member A stated the facility did not have a certified infection preventionist currently. During an interview on 11/21/24 at 3:25 p.m., staff member C stated she had only been in the Infection Preventionist role for about one week. Staff member C stated she was still learning and had not yet completed the infection preventionist training. A request for the Infection Preventionist certificate of training was requested on 11/18/24. No documentation was received by the end of the survey.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 48261 Based on observation, interview and record review, the facility failed to ensure call lights were in reach for residents to call for assistance for 3 (#s 7, 25, and 27) of 18 sampled residents. Findings include: 1. During an observation and interview on 11/19/24 at 8:32 a.m., resident #7's call light was under her bed on the floor. Resident #7 was unable to tell the surveyor where her call light was located. 2. During an observation and interview on 11/19/24 at 10:17 a.m., resident #27's call light was clipped on the wall behind his bed. Resident #27 was unable to state where the call light was located. 3. During an observation and interview on 11/19/24 at 7:59 a.m., resident #25's call light was clipped to the wall behind the bed. Resident #25 was sitting in his recliner. Staff member H entered his room and gave resident #25 his medications. Resident #25's call light was not offered to him before the nurse exited. Resident #25 stated two CNAs came in this morning and helped him get up and did not give him his call light before they left. During an observation and interview on 11/20/24 at 9:54 a.m., staff member M showed the surveyor the lift recliner was not working. While in the room, the call light was on a pillow on the bed. Resident #25 was sitting in his recliner. When asked, the resident attempted to grab the call light and could not reach it. Staff member M stated, That's not really in reach. During an interview on 11/20/24 at 3:03 p.m., staff member C stated all call lights should be within reach of all residents when they are in their rooms. Review of a facility policy titled, Responding to Resident Needs, dated October 2010, reflected: - 1. The primary means for resident to communicate their needs to staff is via the call light. - . d. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.