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	01/15/2026

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

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to provide and maintain a safe environment for 1 (#16) of 19 sampled residents, as evidenced by unsecured medications stored in the resident's bedside nightstand. Findings include:During an interview on 1/12/26 at 2:45 p.m., resident #16 stated she took Tylenol every night for her right knee pain. Resident #16 pulled out a bottle of Tylenol from the top drawer of her nightstand. Resident #16 stated she told the nurses a couple of days ago that she has her own bottle of Tylenol.During an interview on 1/12/26 at 4:40 p.m., resident #16 stated she thought her daughter had brought in the bottle of Tylenol, but wasn't sure. During an interview on 1/13/26 at 1:29 p.m., staff member D stated she did not know resident #16 had Tylenol in her room. Staff member D stated, I always offer her Tylenol, but she never needs it, and tells me she is doing okay. Staff member D stated resident #16 probably got it at some point while out shopping on the facility's bus every Monday.During an interview on 1/14/26 at 11:43 a.m., staff member C stated she did not know resident #16 had Tylenol in her nightstand drawer. Staff member C stated if she found any medications in a resident's room she would tell staff member B right away.During an observation on 1/15/26 at 9:28 a.m., a bottom nightstand drawer in resident #16's room was noted to be completely full of various medication bottles including, but not limited to, Tylenol, Motrin, Aspirin, Premarin, eye drops, and topicals. During an interview on 1/15/26 at 9:30 a.m., staff member C stated she had no idea any of the medications in resident #16's drawer was there. Staff member C stated she would normally see an assessment in the chart for residents who give their own medications, and then stated, But no one that lives here has that.During an interview on 1/15/26 at 9:31 a.m., staff member B stated she was unaware that resident #16 had a full drawer of medications in her room, and did not have an assessment or order for resident #16 to be able to self-administer medications.Review of a facility policy, titled, Resident Self-Administration of Medication, Copyright 2025 The Compliance Store, LLC, reflected the following: . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.

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

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	01/15/2026

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

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to maintain the privacy of personal health information, when a resident's height and weight were posted outside of the resident's door in a public location for 1 (#15) of 19 sampled residents. This deficient practice caused the resident to be disgusted by the posting. Findings include:During an observation on 1/12/26 at 2:18 p.m., resident #15's door had a piece of paper on the outside of her door which showed her height and weight.During an observation and interview on 1/14/26 at 8:12 a.m., resident #15's height and weight were posted on the outside of the resident's room door in public view. Resident #15 was asked if she gave permission for her height and weight to be posted on the outside of her room door in the public's view. Resident #15 replied, no, and stated she didn't think her height and weight were anyone's business. Resident #15 stated that posting her height and weight on the outside of her door was sick and questioned if the posting was ethical. Resident #15 reported no one had spoken to her about the posting and stated her height and weight should be kept private and out of the public's view. Resident #15 further stated the posting of her height and weight was disgusting.During an interview on 1/14/26 at 8:19 a.m., staff member H stated the height and weight posting on the outside of resident doors was posted when residents were admitted to the facility and used as a tool to remind CNAs to get the resident's weights.During an interview on 1/14/26 at 8:20 a.m., staff member G stated she did not ask resident's permission to post their height and weight outside of resident room doors. Staff member G stated there is potential for the resident to be negatively affected from height and weight being posted in view of the public.During an interview on 1/14/26 at 8:23 a.m., staff member B, said height and weight posting on the outside of the resident's door was a reminder for the CNAs to obtain weights upon admission to the facility and staff forget to take the postings down, especially when there was new staff. Staff member B said permission to post the weights on the outside of the door was obtained when a resident signed the consent to treat upon admission.Review of the facility's policy titled, Promoting/Maintaining Resident Dignity, not dated, showed, Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity a well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.Compliance Guidelines:1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.12. Maintain resident privacy.

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	01/15/2026

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

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain evidence of Ombudsman notification for a resident who was transferred to the hospital for 1 (#6) of 19 sampled residents. This deficient practice limited the Ombudsman's opportunity to review the facility's transfer protocols. Findings include:Review of resident #6's hospital discharge summary showed she was admitted to the hospital on [DATE] and discharged on 9/29/25.During an interview on 1/14/26 at 4:04 p.m., staff member I stated the Ombudsman was notified of transfers and discharges twice per month and the notification was done verbally.During an interview on 1/15/26 at 8:26 a.m., staff member G stated she notified the Ombudsman of transfers and discharges when the Ombudsman visited the facility. Staff member G stated the notification was verbal and informal. Staff member G stated she did not have documentation of the Ombudsman notification for resident #6's transfer on 9/26/25.A voicemail was left for the Ombudsman on 1/14/26 at 4:11 p.m., concerning the facility's process for Ombudsman notifications of facility transfers and discharges. There was no return call prior to the end of the survey.A request was made for Ombudsman notification for resident #6's hospital transfer on 9/26/25, on 1/14/26 at 3:45 p.m. Evidence of the notification was not provided prior to the end of the survey.Review of the facility's policy titled, Transfer and Discharge (including AMA), implemented on 4/11/25, showed, .Policy Explanation and Compliance Guidelines:.5. The facility will maintain evidence that the notice was sent to the Ombudsman.9. Non-Emergency Transfers or Discharges.d. The facility will provide transfer/discharge notice to the resident/representative and Ombudsman as indicated.10. Emergency Transfer to Acute Care.h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices.

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	01/15/2026

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

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comprehensively assess a resident's diagnosis of dementia for 1 (#2) of 19 sampled residents. This deficient practice had the potential to prevent the resident from achieving his highest practicable physical and mental well-being. Findings include: During an observation and interview on 1/12/26 at 2:14 p.m., resident #2 was sitting in his room attempting to turn off his radio. Resident #2 stated he was having trouble working both his television and his radio. Resident #2 was confused about the buttons and what they controlled on the television. During an interview on 1/15/26 at 9:45 a.m., staff member G stated, A diagnosis of dementia should be on the Minimum Data Set Assessment if the resident has a diagnosis of dementia. Staff member G said resident #2's diagnosis of dementia should have been on the Minimum Data Set Assessment since resident #2 had a diagnosis of dementia upon admission. Review of resident #2's medical record showed a diagnosis of unspecified dementia with a date of 4/16/24. Resident #2 was admitted to the facility on [DATE], so the diagnosis was not added on admission.Review of resident #2's Minimum Data Set Assessment, with an Assessment Reference Date of 10/2/25, showed the resident did not have Non-Alzheimer's Dementia, due to how the assessment was coded, which reflected: .Section I: Active Diagnoses: I4800. Non-Alzheimer's Dementia: No.The assessment showed the resident did not have dementia. The facility failed to identify and ensure that resident #2's diagnosis of dementia was accurately coded and reflected on the Minimum Data Set Assessment. The diagnosis was not documented on the MDS until the most recent Quarterly Minimum Data Set Assessment, with an Assessment Reference Date of 1/2/26, which was two years after the resident's admission. on 1/30/24.

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	01/15/2026

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

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to include wound care on the 48-hour baseline care plan for a newly admitted resident with multiple wounds for 1 (#44) of 19 sampled residents. This deficient practice resulted in staff not knowing the specific care requirements for the resident. Findings include:During an interview on 1/13/26 at 9:58 a.m., NF4 stated resident #44 had a lot of sores when he was discharged from the hospital and admitted to the facility. NF4 stated the facility assessed his wounds when he arrived.During an interview on 1/14/26 at 9:14 a.m., staff member C stated wounds should be on the resident's baseline care plan. During an interview on 1/14/26 at 1:26 p.m., staff member B said a baseline care plan assessment is completed by the two admission nurses when conducting the admission. The baseline care plan should be filled out completely with all information for staff to provide care for the resident.During an interview on 1/15/26 at 10:15 a.m., staff member I said wounds should have been addressed on the baseline care plan, and they got missed for resident #44. Review of resident #44's baseline care plan, with an initiation date of 1/6/26, showed:. Physician's orders, see MAR.2. Is the resident at risk for skin integrity issues?-2a. If the resident is at risk for skin integrity issues, select the appropriate focus statement, goals, and interventions to address skin integrity: - Focus: Potential for altered skin integrity related to: - Intervention: Encourage good nutritional and oral fluid intake, - Intervention: Encourage/prompt resident to change positions., - Intervention: Nurses to perform weekly skin assessments., - Intervention: Staff will assist resident to turn/reposition., - Intervention: Staff will promote clean skin by encouraging/assisting resident to bathe regularly., - Intervention: Staff will provide prompt peri-care after incontinent episodes., - Intervention: The resident uses the following devices for pressure reduction: Heel protectors. The baseline care plan for resident #44 failed to show interventions for wound care and treatments. Review of a facility document titled Baseline Care Plan, with an implementation date of 4/23/25, showed: Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. [sic]Policy Explanation and Compliance Guidelines:1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: . ii. Physician orders.

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	01/15/2026

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to comprehensively care plan and implement the use of a hand splint to prevent further left hand and wrist contractures for 1 (#6); and failed to include a diagnosis of dementia and interventions for 1 (#2) of 19 sampled residents. The deficient practice increased the risk of further contractures for the resident and had the potential to keep the residents from meeting their highest practicable well-being. Findings include:1. During an observation on 1/13/26 at 9:32 a.m., resident #6 was observed seated in her wheelchair with a support platform mounted on the left-hand side of her wheelchair to support her left hand and arm. Resident #6 was observed with her left hand in a flexed position. Review of resident #6's occupational therapy evaluation and plan of treatment for the certification period of 7/18/25 – 9/15/25, showed that resident #6 was being treated for Hemiplegia and hemiparesis following cerebral infarction affecting her left dominant side, Weakness, and Muscle weakness (generalized). The objective progress/short-term goals identified a new goal to evaluate for the appropriate left-hand splint to prevent further left-hand and wrist contracture with a target date of 9/15/25. The evaluation included, Had splint previously, but has not been wearing it. The evaluation further noted an increased generalized tightness with the resident's left upper extremity, and a near contracture at the wrist. Review of the resident #6's occupational therapy discharge summary, with dates of service ranging from 7/18/25 to 8/12/25, showed a new hand splint was to be ordered, and the comments included that the splint would be fitted upon arrival. During an interview on 1/15/26 at 8:40 a.m., staff member I stated resident #6's care plan needs to be more specific as it related to the care of the near contracture and use of the interventions in place to decrease the worsening of the near contracture. During an interview on 1/15/26 at 9:14 a.m., staff member O stated the condition of resident #6's hand and wrist near contracture were permanent, and a splint was ordered back in September of 2025. Staff member O said near contractures needed care planned interventions to prevent further contractures. During an interview on 1/15/26 at 7:57 a.m., staff member B said there was a lot of information on resident #6's care plan that didn't carry over from her prior admission. Staff member B stated there were new staff members completing the MDSs, and because they didn't know resident #6, the staff members took some of the care planned information out of the current care plan. During an interview on 1/15/26 at 8:32 a.m., staff member J stated she would expect contracture or near contractures to be on the care plan. During an interview on 1/15/26 at 10:57 a.m., staff member N said resident #6 does have a splint for her left hand, and it should be on her left hand, or it was in her room. Staff member N stated she had been trained on the placement of the splint for resident #6. Review of resident #6's comprehensive care plan, last reviewed on 10/29/25, lacked the intervention of a hand splint to prevent further contractures. (continued on next page)

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	01/15/2026

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

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation and interview on 1/12/26 at 2:14 p.m., resident #2 was observed trying to shut off his radio. It took some time before he found the right button and shut off the radio. Resident #2 stated he was also having trouble with his television. Resident #2 had some confusion when talking about his medical conditions and his time at the facility, stating that he . needs to go offsite to sell his paintings, or the facility will just take all of the money for themselves. During an interview on 1/14/26 at 7:49 a.m., staff member F stated, We have had dementia training and have been taught how to redirect residents with dementia. If a resident has dementia, it should be on the care plan with interventions. During an interview on 1/14/26 at 1:26 p.m., staff member B stated, The MDS coordinator used to do the care plans. Since that staff member left, the care plans are a mess. There is a lack of communication and too many people working on them. Staff member B stated, If a resident has a diagnosis of dementia, it should be on the care plan and include interventions. During an interview on 1/14/26 at 9:14 a.m., staff member C stated, If a resident has a diagnosis of dementia, it should be on the care plan and include interventions. During an interview on 1/14/26 at 2:40 p.m., staff member J stated she would expect to see a diagnosis of dementia care planned with interventions for anyone with a diagnosis of dementia. During an interview on 1/15/26 at 8:57 a.m., staff member G stated resident #2 had been admitted from another facility and had a diagnosis of dementia present since 4/2024. Review of resident #2's medical record showed: Diagnosis: Unspecified Dementia, mild, without behavioral disturbance, psychotic, mood disturbance, and anxiety, with a date of 4/16/24. Classification: Admission. Review of resident #2's comprehensive care plan, with a revision date of 1/8/26, failed to show a diagnosis of dementia and any related interventions. Review of a facility document titled Comprehensive Care Plans with an implementation date of 4/11/25, showed: Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. [sic]

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	01/15/2026

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary treatments and services to a resident with wounds, to promote healing of the wounds, and the physician's orders for the wound treatments were not implemented in a timely manner, for 1 (#44) of 19 sampled residents. This deficient practice increased the risk of infection and worsening of the wounds. Findings include:During an interview on 1/13/26 at 9:58 a.m., NF4 stated resident #44 had multiple wounds when he got to the facility, and said, He even had sores on his feet. NF4 stated, The facility staff assessed all of the wounds and took notes on them as soon as he (#44) got to the facility. During an interview on 1/14/26 at 1:26 p.m., staff member B stated resident #44 was admitted to the facility on the 5th or 6th of January 2026. Staff member B stated that resident #44 had multiple wounds on admission, and the facility had assessed them. Staff member B stated, The sore on his bottom was dressed with a foam dressing and should be changed every three days, the sores on the toes should be painted with betadine and left open to air, the sores on his calves should be covered and changed every three days. Staff member B stated, I thought the orders were put in the computer when he was admitted . I didn't realize they (staff) weren't documenting the dressing changes, and the orders were put in late. The nurse who was supposed to enter the (physician) orders had forgotten to enter them.Review of resident #44's electronic medical record showed resident #44 was admitted to the facility on [DATE]. Review of resident #44's physician's orders showed all wound care orders were entered into the electronic medical record on 1/12/26. Review of resident #44's Treatment Administration Record, with a printed date of 1/14/26, showed:.L&R coccyx - cleanse with wound cleaner and apply foam dressing in the afternoon every 3 day(s) for wound care, order date: 1/12/26. The order was checked as completed on 1/12/26.-R great toe, R 2nd toe, L 2nd toe, L plantar foot - paint with betadine daily & leave OTA, socks off & no covers on toes while in bed in the afternoon for wound care, order date: 1/12/26. The orders were checked as completed 1/12/26 and 1/13/26.-R heel, L heel & lateral foot - cleanse with wound cleaner, apply foam dressings. Pressure reducing boot to R foot while up in the afternoon every 3 day(s) for wound care, order date 1/12/26. The orders were checked as completed 1/12/26.-L&R coccyx - cleanse with wound cleaner and apply foam dressing as needed, soiling or removal, order date: 1/12/26. There were no checks documented showing that the treatment order was completed. -R lower calf - cleanse with wound cleaner, cover with foam dressing as needed (for) soiling or removal, order date: 1/12/26. There were no documented checks showing the order was completed.Review of the Treatment Administration Record showed the facility failed to enter wound care orders promptly and failed to treat resident #44's wounds for six days after admission. Review of a facility document titled Wound Treatment Management with an implementation date of 4/11/25, showed: Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.7. Treatments will be documented on the Treatment Administration Record or in the electronic health record.

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	01/15/2026

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

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to identify the need for and have processes in place to ensure resident personal refrigerators were maintained and monitored for 1 (#31) of 19 sampled residents. This deficient practice caused the residents' refrigerator to become dirty and to contain expired foods, which could have led to illness. Findings include:During an observation and interview on 1/12/26 at 1:12 p.m., resident #31 stated, A lady used to come in and check the fridge, but no one has in a while. You can look in it, but I wouldn't if I were you; it stinks. Observation of the refrigerator in resident #31's room showed it was at 46 Degrees Fahrenheit. It had a foul odor, and there was a mini pizza that was supposed to be frozen. The pizza in the box was pliable and not frozen. The refrigerator did not have a freezer portion in it.During an interview on 1/14/26 at 7:49 a.m., staff member F said she didn't think residents were supposed to have personal refrigerators in their rooms. Staff member F said maintaining the residents' personal refrigerators was the night nurse's responsibility. During an interview on 1/14/26 at 1:05 p.m., staff member H said she thought night staff were supposed to be monitoring resident fridge temperatures, and there should be a log on the side of the fridge. Staff member H stated, I don't think any residents have a personal fridge. I didn't think they were supposed to have them.During an interview on 1/14/26 at 1:26 p.m., staff member B said she thought the activity department was responsible for the oversight of the residents' personal refrigerators. Staff member B also said the night nurses were supposed to be monitoring the temperature of the fridge. During an interview on 1/14/26 at 2:58 p.m., staff member M said maintenance was supposed to oversee resident personal refrigerators, and the personal refrigerators should be cleaned per the residents' request. During an observation on 1/14/26 at 3:04 p.m., resident #31's personal refrigerator was observed to contain an open bag of Cheetos, three small containers of Folgers coffee, a bottle of salad dressing, chocolate candy bars, a mini DiGiorno pizza in the original packaging, which was observed earlier in the day, and other drinks and chips. The pizza had a best-by date of April 2025, and the box said to keep frozen. The fridge was still 46 degrees Fahrenheit. There was a foul odor upon opening the fridge door. During an interview on 1/15/26 at 8:30 a.m., staff member A said he was discussing this with the staff, and if the family was to bring in a fridge, it should be their responsibility to care for it. Staff member A stated, We will be working on the process moving forward. We knew the resident (#31) had a refrigerator, but did not have a process in place for its maintenance.During an interview on 1/15/26 at 8:37 a.m., staff member I said the resident came from the Assisted Living Facility, and the fridge was grandfathered in, so it was allowed. Staff member I said the fridge was not being maintained.Review of a facility document titled Resident Refrigerators with an implementation date of 4/11/25, showed: Policy: This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned refrigerators.2. Designated facility (Nursing/Activities/Dietary) staff shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator.b. Temperatures will be at or below 41 degrees Fahrenheit, and freezers will be cold enough to keep foods frozen solid to the touch (or in accordance with state regulation).3. (Nursing/housekeeping) staff shall clean the refrigerator weekly and discard any foods that are out of compliance. Nursing staff shall clean up spills as needed or refer to housekeeping staff.

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	01/15/2026

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

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 0801 Level of Harm - Potential for minimal 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. Based on observation and interview, the facility failed to employ a certified dietary manager or full-time dietician to oversee the dietary department duties. This deficient practice increased the risk of nutritional issues for all residents who received or will receive services from the dietary department. Findings include:During an interview on 1/12/26 at 12:49 p.m., staff member I stated the facility does not currently have anyone certified as the manager of the dietary department, and they do not have a full-time dietician. During an interview on 1/15/26 at 10:50 a.m., staff member K stated, I report to my manager, it is (staff member L), she is interim. I am not sure if she is certified. Our previous manager's last day was Christmas Eve. We have never had a formal training process. We are just thrown to the wolves when we start. That has always been a problem.During an interview on 1/15/26 at 10:51 a.m., staff member L stated, I have been filling in for dietary (oversight) since December 22nd. We are in the hiring process for a dietary manager. I had previous experience in printing the dietary tickets and some of the other duties. I am not certified, though.