

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Brendan House		STREET ADDRESS, CITY, STATE, ZIP CODE 350 Conway Dr Kalispell, MT 59901	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to ensure resident representatives were contacted to provide informed consent before medication, vaccine administration, and adaptive equipment/restraints were used for 4 (#s 10, 60, 94, and 99) of 30 sampled and supplemental residents. Findings include: During an observation on 7/28/26 at 9:11 a.m., resident #99's bed was against the wall with the right siderail up. During an observation on 7/30/26 at 9:42 a.m., resident #94 was sleeping in her bed with bilateral side rails up. The bed was against the wall on the right side. During an interview on 7/27/26 at 3:07 p.m., NF3 stated they had difficulty with the facility for resident consents and notifications. NF3 stated even though they were the responsible party legally for multiple residents, including resident #10, #94, and #99, the facility would have the residents verbally or even sign consents for vaccinations and medications. The facility would not notify the responsible party of events. NF3 stated the facility had resident #99 sign a vaccination consent when he legally should not. NF3 stated they requested to have a printed consent to sign to ensure they are dated properly and signed by them as required. NF3 stated they would know the facility had some residents sign consents instead of the responsible party because she would get some consents for one unit but not the other unit when it was time for vaccinations. During an interview on 7/29/26 at 8:54 a.m., resident #99 stated he had a person who handled all of the signatures for consents, and he was not supposed to sign anything. During an interview on 7/29/26 at 4:08 p.m., staff member M stated the nursing staff could find the responsible party by going to a summary page on the EHR for notifications. Staff member M stated the infection preventionist obtained consent for vaccinations, and the doctor obtained consent for medications before ordering. For adaptive equipment, the nurse or resident care manager would call the responsible party for consent. During an interview on 7/30/26 at 10:10 a.m., staff member J stated the expectation of the facility staff was to obtain consent for new medications or adaptive equipment such as side rails prior to administering them. Staff member J stated facility staff would find who the responsible party was by looking at the profile tab in the EHR to inform them of a change or obtain consent. The expectation was to get a new consent for a medication increase and annually for adaptive equipment/restraints. Staff member J stated if the responsible party was not able to be contacted, the residents that were cognitively intact were asked for verbal consent to start the medication or adaptive equipment. Staff member J stated facility staff were aware of guardians and POA's but did not know if they received training on the difference in POA, DPOA, and Guardianship or how some may be split between several people. During an interview on 7/30/26 at 10:23 a.m., staff member C stated nurses could find the responsible party information in two places: either the hard chart or the EHR under the profile tab. Staff member C stated she was not trained on the different types of responsible parties and their roles but had been at former jobs. Staff member C stated she would call whoever was listed in the (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	profile tab for notifications. Review of resident #10's Letters of Permanent Conservatorship, dated 3/13/25, showed the Western Chapter for the Prevention of Elder Abuse was named conservator of resident #10. Review of resident #10's consents showed:- Psychotropic Medication Consent, effective date of 6/2/26, showed it was for pregabalin. The person noted as consenting was resident #10 on 5/31/26, in person/verbal. The note under 2d. If verbal consent obtained, name and title of witness, was, Not required per [facility] policy.- Bedrail Evaluation and Consent - V2, effective date of 5/17/26, with the name of guardian listed without date, type, or witness of consent. Review of resident #94's Court order, Order Appointing Permanent Full Guardian and Conservator of an Incapacitated Person, dated 6/21/23, showed the, The Western Chapter for the Prevention of Elder Abuse was the appointed Guardian for resident #94. Review of resident #94's Consents showed:- Bedrail Evaluation and Consent - V2, effective date 5/17/26, showed the name of the guardian consenting, but did not have a date, type of consent, signature, or witness information completed.- Vaccine Consent - V2, effective date of 6/24/26, printed version showed the guardian signed on 6/26/26.- Psychotropic Medication Consent, effective date 6/8/26, for escitalopram and olanzapine, did not have the goals or behaviors marked for the use of the medications. The name of the guardian was entered with POA, date of consent blank, and In-person (Verbal) was marked with a note of, medications being reviewed during care conference. Section 2d. If verbal consent obtained, name and title of witness, was blank. Review of resident #99's Letters of Permanent, Full Guardianship, dated 12/17/24, showed the Western Montana Chapter for the Prevention of Elder Abuse was appointed guardian of resident #99. Review of resident #99's consents showed:- Bedrail Evaluation and Consent - V2, effective date of 5/17/26, showed the person giving consent was the guardian. The date of consent, type, and witness were blank.- Bedrail Evaluation and Consent - V2, effective date of 6/11/26, showed the person providing consent was resident #99 on 6/11/26 in person/verbal witnessed by a nurse.- Psychotropic Medication Consent, dated 7/12/24, showed it was for trazodone. A handwritten line through the Trazadone and Zydys with a note of, D/C 7/2/24. [sic] No consent for the current order of trazodone was provided before the end of the survey. Review of resident #60's Montana Statutory (Durable) Power of Attorney, dated 4/19/23, showed it was effective immediately for all medical care with a different primary DPOA than the person on the consents. Review of resident #60's consents showed:- Bedrail Evaluation and Consent - V2 with an effective date of 5/17/26, showing consent by POA through email on 5/17/26. The email was not provided.- Opioid Medication Consent -V2 with an effective date of 5/5/26, for oxycodone, showing verbal consent by the State POA by verbal/telephone. Under 2d. If verbal consent obtained, name and title of witness, with a note of, Not required per [facility] policy.- Psychotropic Medication Consent with an effective date of 6/8/26, for aripiprazole and bupropion. Person providing consent: Resident #60, POA verbally in person. Effective date of consent was blank, and witness of consent was blank.- Vaccine Consent - V2 with an effective date of 6/9/26, showed influenza and Boostrix (TdaP) by POA [Parent] verbally by telephone. Review of the facility policy titled Side Rail Use, last reviewed 12/2024, showed, The informed consent for the use of a side rail(s) is signed by the resident/responsible party. This is necessary to show the informed consent of the resident/responsible party with an intervention that has the associated safety risk of entrapment . side rail usage and purpose of side rail will be addressed by IDT with the resident/responsible party at the admission, quarterly, significant change and annual Minimum Data Set (MDS) care plan process conferences. Review of facility policy, [Facility] Vaccines Protocol, no date, showed, .after performing a chart review and Vaccine Consent documentation .		

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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. Based on interview and record review, the facility failed to ensure residents were free from verbal or physical abuse by staff for 1 (#43) of 30 sampled and supplemental residents. This deficient practice was corrected on 11/12/25. Findings include: Review of the facility investigation file, dated 11/12/25, showed the facility had substantiated abuse by a staff member (NF2) against resident #43. Resident #43 reported NF2 had hit her on the arm and called her an asshole. Review of the investigation file on 7/30/26 showed the facility reported the incident according to the required timeframes, assessed the affected resident, evaluated other residents for potential abuse concerns, and kept residents safe from further abuse while the investigation occurred. Staff education on abuse and neglect was completed. QAPI meets monthly and reviews reportable incidents. During an interview on 7/28/26 at 11:15 a.m., resident #43 did not remember or state any concerns related to the incident with NF2, which had occurred last November. Progress notes in the time period afterwards showed follow up evaluations for psychosocial harm, with none noted. The arm bruise was unable to be definitively identified as a result of NF2 hitting the resident's arm, or from her routine insulin injections. During an interview on 7/29/26 at 3:51 p.m., staff members I and K stated NF2 did not have any red flags in her background that were concerning. NF2's employee file contained a passed background check and drug screen. Her abuse and neglect training was up to date, and she did not have any negative occurrences against her license. NF2 started working at the facility on 10/21/25. After the allegation, NF2 was immediately suspended while an investigation occurred, and she never returned to work before her termination upon substantiation of the allegation. Due to the facility's corrective actions taken, this failure was cited as Past Non-Compliance.		