STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275109	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brendan House	350 Conway Dr Kalispell, MT 59901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to provide dignity and privacy for a resident being transported to the shower room for 1 (#53); and failed to provide dignity and privacy for a resident in a dining room without bottoms on, with a catheter, and full catheter bag showing, for 1 (#2) of 3 sampled residents for dignity. This deficient practice resulted in resident #53 feeling embarrassed. Findings include:1. During an observation on 7/15/25 at 8:32 a.m., resident #2 was observed napping in the dining room, in a manual wheelchair, sitting on a chuck (disposable under pad). Resident #2 was facing the dining room and the unit entrance. Resident #2 had her clothing bottoms below her knees. Her catheter was visible, and the full catheter bag was facing outward, without a privacy cover on the outer side. Other residents and several staff were present. Staff weren't addressing the resident's dignity concerns for the visible catheter bag without the cover. During an interview on 7/17/25 at 10:58 a.m., staff member F stated she had been diligently trying several approaches to have resident #2 agree to put her pants on. Staff member F stated that eventually, resident #2 was taken to her room, she used a grab bar to stand, and her pants were pulled up. 2. During an observation on 7/16/25 at 9:02 a.m., staff member M entered resident #53’s room with a white shower chair. Resident #53 was in a hospital gown. Resident #53 was assisted to the shower chair, and he sat down. Resident #53’s back and buttocks were exposed and uncovered while in the shower chair. Staff member M wheeled the shower chair out of resident #53’s room and out past the dining room, where multiple residents and staff were sitting. Resident #53’s back and buttocks were visible to others as he was wheeled past the dining room. The staff member did not attempt to cover the resident's buttocks or back. During an interview on 7/16/25 at 9:30 a.m., staff member M stated residents should be fully covered before leaving their rooms for a shower or bath. Staff member M stated, “I did not check to make sure he (#53) was not exposed. I should have.” During an interview on 7/16/25 at 1:07 p.m., resident #53 stated he was upset and embarrassed that he was exposed to staff and other residents on his way to the shower. Review of a facility policy titled, “Resident Rights and Responsibilities, BHSS907,” with an effective date of 2/2025, showed: … “1. While at [Facility Name], a resident has a right to: … F. Privacy …”

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
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to obtain evaluations and provider orders for residents to self-administer medications for 4 (#s 28, 40, 90, and 93) of 11 residents sampled for self administration capabilities. Findings include:1. During an observation and interview on 7/16/25 at 12:55 p. m., resident #90 was lying in bed with her nebulizer running, and the nebulizer mouthpiece was under her blanket. Resident #90 stated she tried to hold the nebulizer up to her mouth but was busy on her cell phone looking for something and became tired. Resident #90 appeared to be short of breath and was coughing throughout the interview. During an interview on 7/16/25 at 12:56 p.m., staff member L stated he usually set up the nebulizer, and resident #90 completed the nebulizer treatment on her own. Staff member L stated the nurses were responsible for filling out the self-administration of medication evaluation and requesting an order from the physician. Staff member L reviewed resident #90's paper chart and EHR, stating he could not find a self-administration evaluation or an order for resident #90 to self-administer medications. A review of resident #90's EHR reflected that resident #90 had an order for Ipratropium-Albuterol solution 3 ML, inhale orally, four times daily. A review of resident #90's paper chart reflected that resident #90 was seen by the physician on 7/16/25 at 4:15 p.m., and physician orders were received for Mucinex, for the resident's cough, and Augmentin and Doxycycline, for pneumonia. 2. During an observation and interview on 7/16/25 at 8:42 a.m., resident #28 was sitting in his recliner watching television. A cup of pills was on his bedside table next to the recliner. Resident #28 stated, They leave them (the pills), and I take them at some point. During an observation and interview on 7/17/25 at 8:50 a.m., resident #28 was sitting in his recliner watching television. A cup of pills was on the bedside table next to the recliner. Resident # 28 stated, Oh, I should probably take my pills, huh? During an interview on 7/17/25 at 10:27 a.m., staff member L went through the paper charts for resident #28 and stated that resident #28 did not have an assessment or physician order for the self-administration of medications. Staff member L stated resident #28 took a half hour to take his medications because of a swallowing issue, so he leaves the pills with the resident so he can take them at his own pace. A review of resident #28's EHR reflected resident #28 had an order for Ipratropium-Albuterol solution 3 ML, inhale orally, four times daily. 3. During an observation and interview on 7/15/25 at 10:12 a.m., resident #40 had a full cup of pills on her table. There was no staff supervision at the time. Resident #40 set the medications off to the side and stated she would take them later. Review of resident #40's medication administration record, dated 7/15/25, showed that for the a.m. medications she received: Famotidine for acid reflux, levothyroxine for hypothyroidism, acetaminophen for pain, and Eliquis, a blood-thinning medication, for atrial fibrillation. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #40's Annual MDS, with an ARD of 5/19/25, showed she had a BIMS of 7; severe cognitive impairment. Review of resident #40's medical record failed to show she was assessed to safely administer her medications. 4. During an observation and interview on 7/15/25 at 3:22 p.m., resident #93 brought a plastic bag with assorted pills to the nurse. Staff member J stated they had no idea where the resident got them from, and they were not in facility packaging. During an interview on 7/16/25 at 10:37 a.m., staff member I stated that a resident had to have an order for self-administering medications or the nurse would have to remain with and watch the resident take the medications. During an interview on 7/16/25 at 10:42 a.m., staff member J stated “99% of the time we watch the residents take their meds, if I know a resident well, and there are no cognitive issues and no controlled meds, I will sometimes leave the meds with them and keep checking back on them to make sure they took them and didn’t drop any.” During an interview on 7/16/25 at 1:53 p.m., staff member K stated, “The nurses do not leave medications at the bedside. The resident would have to have a medication self-administration assessment and a provider order, for the nurses not to observe the resident taking the meds.” A review of a facility provided list, titled, “Self-Administration,” listed six residents, who were the only residents approved by the facility to self administer medications. Resident #’s 28, 40, 90, and 93 were not on the list. A review of #28, 40, 90, and 93's provider orders, located in the EHRs, failed to show a provider order allowing the resident to self-administer medications. A review of a facility document titled, “Interdisciplinary Team Evaluation of Resident Self-Administration of Bedside Medications,” undated, showed: “… Interdisciplinary Team Evaluation: The interdisciplinary team has evaluated and assessed [blank]’s cognitive, physical and visual ability to carry out the responsibility of self-administering drugs. (Check one) ( ) Yes, [blank] is cognitively, physically and visually able to self-administer all of her/his dispensed medications in a medication cup left at her/his bedside ( ) Yes, [blank] is cognitively, physically and visually able to self-administer certain medications. …”

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record review, the facility failed to ensure the medical provider was notified of a resident's severe weight loss, for one (#6) of 43 sampled residents. This deficient practice did not allow the physician the opportunity to plan or implement weight loss interventions. Findings include: During an interview on 7/15/25 at 8:32 a.m., resident #6 stated she had lost 26 pounds in the last month or two and was not sure why her appetite had declined.Review of resident #6's electronic health record showed resident #6 weighed 308 pounds on 1/6/25 and 248 pounds on 7/16/25, which was a 19.51% loss over the past six months; and on 6/9/25 she [resident #6] weighed 276 pounds, which was a 10.14% loss over the past month. During an interview on 7/16/25 at 9:16 a.m., staff members Z and AA stated resident #6 was independent with feeding herself, and they were not sure why resident #6's appetite was declining. Staff members Z and AA stated resident #6's son and daughter-in-law were aware of the weight loss. During an interview on 7/16/25 at 1:52 p.m., staff members AA and BB stated they were not aware resident #6 had lost 60 pounds over the last six months, or 26 pounds in the last month. During an interview on 7/16/25 at 3:08 p.m., staff member D stated resident #6 was admitted to the Nutrition at Risk Committee in May of 2025. Staff member D stated physicians were to be notified of significant weight losses when residents were admitted or discharged from the Nutrition at Risk Committee. Review of the electronic medical record for resident #6 showed a Nutrition at Risk Committee note, dated 6/24/25 at 2:29 p.m., reflected: .Significant weight loss in 6 months . Resident Care Manager to notify provider of weight loss .During an interview on 7/17/25 at 7:55 a.m. , staff member F stated she did not notify resident #6's physician of the weight loss, I dropped the ball, I should have, it was my fault.During an interview on 7/17/25 at 8:53 a.m., staff member A stated the physician for resident #6 should have been notified of resident #6's significant weight loss in order to be involved with her care. Review of a facility policy titled, Weight/Nutrition at Risk, BH320, last revised 1/2023, showed: .All significant changes in weight (5% in 30 days; 10% in 180 days), .will be reported to the patient's/resident's provider .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews, and record review, the facility failed to provide residents access to grievance forms and the opportunity to file grievances anonymously for 1 (#8) of 43 sampled residents. Findings include: During an interview on 7/15/25 at 1:17 p.m., resident #8 stated the nurse practitioner told him he was dying, and his kidney function was down 63%. Resident #8 stated he was rushed to the hospital, and the hospitalist stated he was not dying, and his kidney function numbers were not that bad, and gave him a bolus of IV fluids. Resident #8 stated he was angry that the nurse practitioner put him and his wife through that trauma. Resident #8 stated he tried to figure out answers from the staff and was not able to get any answers. Resident #8 stated he was not aware of any grievance forms and had not seen grievance forms. Resident #8 stated he was very vocal about his concerns about the nurse practitioner scaring him and his wife with false information, but his wife would most likely want to file a grievance anonymously if she had the opportunity. Resident #8 requested a couple of forms to complete from the surveyor to file a grievance related to his concerns about the nurse practitioner scaring him and his wife with false information, and his concerns with the quality and temperature of food.During an observation on 7/15/25 at 1:30 p.m., no grievance boxes or forms were observed on the walls or in common areas of the unit. During an observation and interview on 7/15/25 at 1:33 p.m., staff members U, E, and Y looked through the nursing station on the unit and the file cupboards but were not able to locate any grievance forms. Staff member E called staff member B, who stated she would bring a form to the unit. Staff member E stated the forms were not kept on the units in the years she had worked for the facility.During an interview on 7/15/25 at 1:37 p.m., staff member H stated he had a form on his computer but was unsure of the process for handling it and would need to call staff member B for the process. Staff member H stated the forms were not readily available for residents to use anonymously.During an interview on 7/15/25 at 1:45 p.m., with staff member B and J, staff member B was unable to find grievance forms on the 400-hall but did locate forms in the back office on the 600-hall. Staff member J stated he did not know where to find the forms and would need to call a manager on duty for assistance and did not know how residents would complete a grievance anonymously.During an interview on 7/15/25 at 2:01 p.m., staff member A stated the residents did not have access to grievance forms on the units to complete them anonymously. Staff member A stated that the residents can ask staff for a form. Staff member A stated the form staff member B found in the 600 hall was not the correct form. Staff member A stated the facility preferred to address concerns in the moment rather than handling forms filed anonymously.A review of the facility's policy, Patient Complaints and Grievances, revised 7/2025, reflected:- 1. At the time of admission or check-in, patient registration staff will provide patients and patient representatives with the Patient Rights & Responsibilities, which will describe how to submit Complaints and Grievances as well as the investigation and resolution process. There was no information or instructions for residents to file a grievance anonymously. A review of the facility provided, Facility Rights and Responsibilities, dated 4/15/25, reflected:- . (20) GRIEVANCES. To voice grievances to the facility or the resident council about care or treatment you or other residents receive, without discrimination or reprisal. The facility shall establish written procedures for receiving, promptly handling, and in- informing you or the resident council of the outcome of any grievance presented, including those with respect to the behavior of other residents. You also have the right to ask a state agency or a resident advocate for assistance in resolving grievances, free from restraint, interference, or reprisal. There was no information or instructions for residents to file a grievance anonymously.A review of the facility provided list of grievances, with no date, did not reflect any grievances filed for resident #8, including after he returned from the hospital and voiced his concerns.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to keep a resident free from a physical restraint for 1 (#60) of 1 sampled resident. This deficient practice caused the resident to be unable to get out of a Broda chair independently, and caused the resident to be agitated and yell to get out of the chair. Findings include:During an observation on 7/16/25 at 8:42 a.m., resident #60 was sitting in a Broda chair. The back of the chair was reclined at about a 45-degree angle, and the footrest was in the up position. The resident's feet were unable to reach the floor. Resident #60 was sitting parallel to a table in the dining room. Resident #60 was yelling that he wanted out of the chair, and he was trying to climb over the arm of the chair. During an observation on 7/16/25 at 8:52 a.m., resident #60 continued to be in the Broda chair, sitting parallel to a table in the dining room. Resident #60 was attempting to get out of the Broda chair, but he was not able to. The Broda chair was reclined at about a 45-degree angle, and the footrest was in the up position, so his feet were not able to reach the floor. Resident #60 became agitated, then he threw a blanket and three pillows onto the floor in the dining room. Resident #60 stated, Get me out of this chair, multiple times. Resident #60 tried to climb over the arm of the chair and slide off the end of the chair.During an interview on 7/16/25 at 9:12 a.m., staff member N stated, We put [Resident #60] in the Broda chair to prevent falls. From what I understand, he was falling out of his wheelchair all the time, so we started putting him in this one (Broda chair) so he couldn't fall. During an interview on 7/16/25 at 10:17 a.m., staff member S stated she frequently worked with resident #60, and the use of the Broda chair was either a directive of nursing or physical therapy. Staff member S stated that resident #60 had been using the Broda chair for about three months. During an observation on 7/16/25 at 12:55 p.m., resident #60 continued to sit in the dining room in the Broda chair. Resident #60 appeared anxious and agitated, stating, I want out of this chair, get me out of this, repeatedly. During an interview on 7/16/25 at 1:05 p.m., staff member LL stated that resident #60 was always upset when he was in the Broda chair, but he would fall out of his wheelchair.During an interview on 7/16/25 at 1:42 p.m., staff member N stated, [#60's name] is uncooperative and agitated today. Staff member N stated the (Broda) chair was most likely the cause of resident #60's agitation. Staff member N stated he was not sure of any alternative interventions implemented for the falls, before the use of the Broda chair, for resident #60.A review of resident #60's care plan, dated 3/1/25, with a revision date of 6/24/25, showed no alternate interventions for falls were attempted prior to the use of the Broda chair.A request for the restraint policy and procedure was made on 7/16/25.During an interview on 7/16/25 at 2:30 p.m., staff member A stated there was no policy or procedure for restraints because the facility was a restraint-free facility.During an interview on 7/17/25 at 7:50 a.m., staff member P stated she had not worked at the facility for very long. Staff member P stated if a resident needed a different type of chair or special equipment, physical therapy should do an assessment and give a recommendation on the equipment. Staff member P stated she did not believe an assessment had been completed on resident #60 for the use of the Broda chair and did not believe an assessment was done to assess the safety of resident #60 in the Broda chair.Review of resident #60's Physical Therapy Discharge Summary, dated 2/26/25, showed: Equipment issued: Recommend continued use of hospital bed, full body mechanical lift for transfers and standard manual w/c.Review of resident #60's Significant Change MDS, with an Assessment Reference Date of 6/25/25, showed a restraint was not coded.Review of #60's physician orders, dated 2/2025 to 7/17/25, showed no physician order for a restraint.

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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 complete a baseline care plan within 48 hours of admission, to include the minimum health information necessary to properly care for 1 (#87) of 6 residents sampled for baseline care plans. This deficient practice puts the resident at risk of not receiving necessary care and services. Findings include: During an interview on 7/16/25 at 10:40 a.m., staff member N stated he does not review the resident care plans, and he did not look at resident #87's baseline care plan.During an interview on 7/18/25 at 8:35 a.m., staff member E stated she helped oversee the care planning process and ensured staff are following the care plans. Staff member E stated baseline care plans are completed within 48 hours of admission. Staff member E stated that nursing staff were supposed to help initiate and update care plans.Review of resident #87's baseline care plan, dated 6/27/25 at 5:47 p.m., showed the baseline care plan was not filled out and did not identify any information pertinent to care for the resident. Baseline care plan information did not include resident #87's cognitive status, ADL status, bowel or bladder status, transfer status, respiratory status, specifically oxygen use, communication status, mobility device use, or type of diet. Review of Resident #87's diagnosis list showed a diagnosis of Lung Cancer, Pain and Diabetes Mellitus, Type II.Review of a facility policy titled Care Planning Process, BH125, with a revision date of 3/2025, showed: . The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being Care plans are initiated upon admission .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 implement care planned assessments for seatbelt use for 1 (#1); failed to include pertinent resident care items including cardiac monitoring and CPAP settings into a comprehensive care plan for 2 (#s 12 & 19); failed to include focus, goals, or interventions on the comprehensive care plan for oxygen use and nutritional supplement use for 1 (#87); and failed to include ADL's and mobility on a comprehensive care plan for 2 (#s 30 and 87) of 43 sampled residents. Findings include:1. During an interview on 7/17/25 at 7:43 a.m. staff member G stated resident #12 had been moved to the pod in May, and she was currently working on her most recent MDS assessment to trigger care plan updates. Staff member G stated care plan updates were also ongoing as resident concerns developed, and this would trigger an update for additional devices or medications. Review of resident #12's hospital H&P, dated 2/20/25, showed the resident had been admitted for syncope and collapse, which resulted in the resident having a cardiac pacemaker placed. Review of resident #12's nursing progress notes, dated 7/7/25, showed, The cardiac monitoring company called this morning to say [Resident #12's] pacemaker monitor was offline … The facility had further communications to replace the lost monitor. Review of resident #12's comprehensive care plan, with an initiation date of 1/31/25, failed to show the resident was on any cardiac monitoring. 2. During an interview on 7/16/25 at 2:12 p.m., resident #19 stated she had always been an anxious person, but was having increased anxiety at night, which worsened her respiratory status. Resident #19 stated she had a paid caregiver who would stay with her at night when she lived at home, and she continued to pay this person to stay with her at night, from 11:00 p.m. to 6:00 a.m., in the facility as well. Resident #19 stated she had a bipap mask to wear when she slept, but it made her very claustrophobic, and she was reluctant to wear it even though she understood it would help when her breathing was difficult. Review of resident #19's physician orders, dated 7/2/25, showed, BiPAP as HS and prn 3L O2 bleed in Trial of nasal bipap over mouth mask. [sic] Review of resident #19's care plan, with an initiation date of 5/8/25, failed to show any documentation of the resident's nighttime sitter. The focus area of CPAP/BiPAP therapy did not have any interventions listed. 3. During an observation on 7/14/25 at 4:15 p.m., resident #87 was lying in bed with oxygen on, and the oxygen concentrator was set to 1.5 liters. There were three full, unopened containers of sugar-free boost, sitting next to his television. A walker was present in the room. During an interview on 7/15/25 at 8:08 a.m., resident #87 stated he had a diagnosis of lung cancer that had spread, and he was terminal. Resident #87 stated he used oxygen all the time. Resident #87 stated he has had a decrease in his appetite, but the facility was providing him with boost at mealtimes. Resident #87 stated he does not always drink them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #87’s physician’s orders, dated 6/27/25 -7 /14/25, showed no physician order for the resident's oxygen use or the nutritional supplements provided at meals. Review of resident #87’s comprehensive care plan, with an initiation date of 7/9/25, showed no focus, goals, or interventions for oxygen use or nutritional supplement use. During an observation and interview on 7/15/25 at 10:15 a.m., resident #30 was sitting in a wheelchair at a table in the dining room, reading a book. Resident #30 stated he was able to move his wheelchair on his own by using his feet. During an interview on 7/15/25 at 2:41 p.m., NF3 stated resident #30 had memory problems and required assistance with his ADLs and mobility. During an observation on 7/16/25 at 12:40 p.m., resident #30 was in his wheelchair and was propelling himself, using his feet, back to his room. Review of resident #30’s comprehensive care plan showed no focus, goals, or interventions for ADL’s or his mobility. During an interview on 7/16/25 at 11:04 a.m., staff member S stated that residents #30 and #87 required assistance with ADLs and mobility. Staff member S stated she had a paper, which included information that showed her what each resident needed assistance with. Staff member S stated she did not look at the care plan, just the paper she had, which was basically a care plan. During an interview on 7/18/25 at 8:35 a.m., staff member E stated she helped oversee the care planning process and ensured staff were following the care plans. Staff member E stated care plans were done on admission, quarterly, annually, and with any significant change. Review of resident #87’s comprehensive care plan showed: “Focus-The resident has an ADL self-care performance deficit r/t Date initiated 7/14/25. Goal-Resident will improve current level of function in (SPECIFY ADLs) through the review date. Resident will be able to: (SPECIFY). Interventions-Praise all efforts at self care.” [sic] Review of a facility CNA document showed: “Resident #30- Bed: Ax2, Trans: Ax2, Gait Ax1 / WC. Resident #87-Bed: Ax1, Trans: Ax1 FWW, Gait: Ax1 FWW.” 4. During an observation on 7/16/25 at 10:13 a.m., resident #1 was in his wheelchair in the 100-hall, and there was a seatbelt attached to the chair. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brendan House	350 Conway Dr Kalispell, MT 59901

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/16/25 at 10:40 a.m., staff member N stated the nursing staff had become normalized” to resident #1 looking like he was going to fall out of his chair, due to his sliding down. During an interview on 7/17/25 at 8:30 a.m., with staff members A and H, staff member A stated physician orders for the seatbelt use were obtained one time. Staff member H stated that physician orders were completed when a device was initially implemented, and no further orders were needed after. Staff member A stated the facility did not have a policy specific to seatbelt use. During an interview on 7/17/25 at 10:16 a.m., staff member E stated when the facility changed to Point Click Care (electronic health record system), there was no template for the assessment for seatbelt use in residents, and this was why the quarterly assessments had not been done for resident #1 since October 2024. Review of resident #1’s care plan, reviewed on 5/25/25, showed: - “Obtain physician’s order to approve use of seat belt (ordered 12/2/23),” “Assess quarterly that [resident #1] continues to be able to unbuckle as he/she wishes and that the safety belt is still functioning in helping with positioning needs in wheelchair.” Review of a facility policy titled, “Care Planning Process, BH125,” with a revision date of 3/2025, showed: … “The care plan must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental and psychosocial well-being. … 4. Care plans are individualized to address the resident’s problems, needs, severity of condition, impairment, disability, or disease. The care plan addresses needs and care priorities…” [sic] A review of the facility’s policy, Care Planning Process, last revised 3/2025, showed, “… The interdisciplinary team collaborates throughout the provision of care to implement interventions that help achieve optimal outcomes and to communicate and coordinate the support of the resident needs and care goals.”

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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. Based on interview and record review, the facility failed to update care plans as resident conditions and physician orders changed for 2 (#s 13 and 60) of 43 sampled residents. Findings include:1.Review of a facility document provided to resident #60’s physician, dated 6/11/25, showed: … “Resident #60 has poor appetite and intake he does drink his boost… Staff attempt 1 on 1 with meals and encourage intake…” Review of resident #60’s care plan, with an initiation date of 6/11/25, showed severe weight loss as a focus area. The care plan was not updated to include one on one feeding provided by staff as needed or the use of nutritional supplements. During an interview on 7/16/25 at 1:05 p.m., staff member LL stated, During an observation and interview on 7/16/25 at 1:05 p.m., staff member LL picked up resident #60’s meal tray and put it in a cart to be thrown away. Everything on the meal tray was still covered and untouched. Staff member LL stated, We don't make him (resident #60) eat, he is on comfort care. During an interview on 7/16/25 at 3:10 p.m., staff member D stated, “Resident #60 is on comfort care, so we can’t make him eat. Staff member D stated resident #60 was being followed in the nutrition at risk meetings because of his weight loss. Staff member D stated patient #60 requires encouragement and one on one occasionally with meals, and staff are to be offering alternative meals if he does not eat. During an interview on 7/18/25 at 8:35 a.m., staff member E stated she helped oversee the care planning process and ensured staff were following the care plans. Staff member E stated care plans were done on admission, quarterly, annually, and with any significant change. Staff member E stated it was her expectation that nurses on the floor also assist in revising resident care plans. 2. During an interview on 7/17/25 at 7:43 a.m., staff member G, stated resident care plans were updated in an ongoing matter as things developed. Adding something like a catheter, medications, or behaviors would indicate a care plan update. Review of resident #13's physician orders, dated 7/9/25 - 7/11/25, showed the resident's catheter was removed for a voiding trial and there were orders to, bladder scan every four to six hours and straight cath for retention of greater than 500ml urine. Review of resident #13's care plan, with an initiation date of 7/8/25, showed risk for infection due to indwelling catheter as a focus area. The care plan had not been updated to include the removal of the catheter or the two new orders of bladder scanning and as needed straight catheterization. Review of a facility policy titled, “Care Planning Process, BH125,” with a revision date of 3/2025, showed: … “2. Care plans are reviewed and updated after each MDS assessment, and as the resident’s needs and strengths change, and to update time frames, goals, approaches, and objectives.”

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide assistance with meals for a resident who required encouragement and one on one for eating for 1 (#60) of 5 sampled residents for nutrition. This deficient practice increased the risk for the resident not receiving necessary care and services with meals. Findings include:During an observation on 7/15/25 at 8:15 a.m., resident #60 was lying in bed sleeping. Resident #60's breakfast tray was sitting on his bedside table, covered and untouched.During an observation on 7/16/25 at 8:42 a.m., resident #60 was sitting in a Broda chair parallel to the table, with his feet elevated and the back of the chair reclined. Resident #60's breakfast tray was sitting on the table. The tray had a cover over the plate of food, the milk and juice each had a cover over them, and the container of boost was unopened. Staff member N was the only staff member near the dining area. Resident #60 could not reach his tray of food.During an observation on 7/16/25 at 8:45 a.m., staff member R entered the dining area and picked up resident #60's meal tray. Staff member R did not offer any assistance to resident #60 or offer an alternative prior to taking the tray away.During an interview on 7/16/25 at 8:58 a.m., staff member S stated resident #60 was agitated and that was probably why he did not eat. Staff member S stated staff was to encourage resident #60 to eat or provide one on one assistance to resident #60.During an observation on 7/16/25 at 12:55 p.m., resident #60 was sitting in a Broda chair with the feet elevated and the back reclined. The Chair was parallel to the dining table. Staff member LL was sitting at the end of the dining table with two residents between resident #60 and staff member LL. Resident #60's meal tray was still covered, and he could not reach his fluids. Resident #60 stated, Hell yeah, I'm hungry. Staff member LL got up from the end of the table and sat next to resident #60. Staff member LL did not uncover the meal tray or attempt to encourage or assist resident #60 with his meal.During an observation and interview on 7/16/25 at 1:05 p.m., staff member LL picked up resident #60's meal tray and put it in a cart to be thrown away. Everything on the meal tray was still covered and untouched. Staff member LL stated, We don't make him (resident #60) eat, he is on comfort care.During an observation on 7/16/25 at 1:20 p.m., resident #60 was sitting in the dining area yelling, I'm hungry.During an interview on 7/16/25 at 1:30 p.m., staff member S stated resident #60 feeds himself, staff do not need to assist him, but there are times when he needed encouragement to eat. Staff member S stated breakfast comes to the unit about 7:15 a.m. and lunch arrives about 12:15 p.m.During an interview at 1:35 p.m., staff member N stated resident #60 feeds himself. Staff member N stated, Today he (the resident) is just agitated and uncooperative, so he's not eating.During an interview on 7/16/25 at 3:10 p.m., staff member D stated, Resident #60 is on comfort care, so we can't make him eat. Staff member D stated resident #60 was being followed in the nutrition at risk meetings because of his weight loss. Staff member D stated patient #60 requires encouragement and one on one occasionally with meals, and staff are to be offering alternative meals if he does not eat.During an observation on 7/17/25 at 8:12 a.m., resident #60 was lying in bed asleep. Resident #60's meal tray was on his bedside table.Review of resident #60's care plan showed: Focus: Severe weight loss-date initiated 6/11/25,Goal: Resident to consume greater than 50% of each meal-initiation date 6/11/25.Interventions: Encourage to eat 50 percent or more of meals.-If intake 50 percent or less, offer substitute or supplement.Review of a facility document titled, Weight/Nutrition at Risk, BH320, with an effective date of 3/2025, showed:. 4. To ensure all residents are having their nutritional needs met.

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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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure an Unstageable pressure injury received care and services to prevent worsening of a pressure injury after admission for 1 (#5) of 3 sampled residents for pressure ulcers. Resident #5 was admitted with an Unstageable pressure injury to his right heel. There was a lack of information to determine if the wound was worsening. Findings include:During an observation and interview, on 7/16/25 at 11:11 a.m., staff member I performed a dressing change on resident #5's right heel. Staff member I donned clean gloves and removed the soiled dressing. The dressing was saturated with yellow exudate and yellow slough was covering the wound. The wound was not cleansed prior to putting the clean dressing on. Staff member I stated wound care orders were usually on the TAR, but she did not see any orders for wound cleansing. The wound was covered with Aquacel and wrapped in Kerlix. During an interview on 7/17/25 at 8:48 a.m., staff member E stated resident #5 was supposed to have boots on for offloading. Staff member E stated, for wound prevention, the resident had an air mattress. Staff member E stated a foot cradle was tried, but the resident did not like it. Staff member E stated the resident was also supposed to be turned and repositioned. Resident #5 was identified to have nutrition at risk. Staff member E stated staff member D had recommended Juven for the resident for wound healing. Resident #5 was to receive every other day dressing changes. During an interview on 7/17/25 at 9:30 a.m., staff member MM stated resident #5 was to use a boot (pressure relieving) on his heel, be turned and repositioned, his bed had an air mattress, and staff were to float his heels while in bed. Staff member MM stated the resident was to leave the boot on all day. Staff member MM stated resident #5 was to be up to the dining room for meals. During an interview on 7/17/25 at 9:58 a.m., staff member B stated there was a policy for wound care, and upon admission staff were to assess and evaluate any wounds the resident had. The interventions were to be care planned and staff were to follow physician orders for wound care. Staff member B stated the staff had pressure ulcer training recently. Staff member B stated the resident came in with the wound to his right heel.Review of resident #5's wound consult notes showed the wound was Unstageable on 6/23/25, and it was a Stage II pressure injury on 7/7/25. The note on 6/23/25 showed the wound was Unstageable due to the inability to debride the wound due to pain. No additional wound care notes were provided during the survey.Review of resident #5's Orthopedic Progress Notes, showed the heel wound was described as having partial thickness, and the resident had a boot for offloading.Review of resident #5's Skilled Nursing visits showed the heel wound was Unstageable on 6/14/25 and 6/20/25. On 7/3/25 the heel wound was to be offloaded continuously to ensure wound healing and wound care had been consulted on 6/23/25. On 7/8/25, the heel wound was not mentioned. An addendum to a note, dated 6/30/25 for the encounter note dated 6/25/25, showed the heel wound was being managed by the wound team and offloading with daily dressing changes.Review of a Skin and Wound Evaluation, dated 7/10/25, showed the heel wound was an Ustageable pressure deep tissue injury present on admission which measured 2.9 cm x 2.2 cm. The wound had light seropurulent drainage with a faint odor. The wound was documented as slow to heal. This was the only Skin and Wound Evaluation provided by the facility. Review of the facility policy, titled Skin and Wound Care, showed any skin breakdown on admission was to be reported to the provider, the family member and/or the Representative and the Resident Care Manager immediately. All identified pressure or open wounds were assessed, photographed, and measured weekly by the licensed nurse in order to identify progress towards healing, and any new treatments needed.The heel wound documentation provided by the facility did not show measurements, or weekly assessments, and did not show complete wound care including cleansing the wound.Review of resident #5's Care Plan showed there were not any new interventions or changes for wound management since 6/21/25. Interventions included evaluation, monitoring, and measuring the wound at regular intervals, but time frames were not specified.Review of the facility policy titled, Skin, Wound and Pressure Injury Prevention showed: . skin, wound and pressure injuries will be treated using the skin, wound and pressure injury care guideline . Comprehensive wound and pressure injury documentation will be completed weekly until discharge, unless otherwise indicated per provider's direction. Photograph wound or pressure injury on admission . Photographs will be completed once weekly until discharge.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to prevent a severe weight loss in 1 (#5); and the facility failed to complete weekly weights for four weeks, on a new admission for 1 (#87) of 6 sampled residents for nutrition. Findings include:1. During an interview on 7/16/25 at 3:13 p.m., staff member D stated all physicians were notified when a resident was brought to NAR (Nutrition at Risk). Staff member D stated she could not write nutrition orders, but she could order supplements. Staff member D stated weights were supposed to be obtained the first weekend of the month. Staff member D stated she pulled reports on resident weights the following week. Staff member D stated the staff also sent a message if the resident had weight loss. Staff member D stated resident #5 was being followed by NAR, was receiving chocolate glucose control supplement, and Juven. Staff member D stated resident #5 had a significant decline related to progressing dementia. Staff member D stated care plans were updated quarterly, annually, and on admission. Staff member D stated if the care plans needed updated between the quarterly, annually, or on admit, it was the responsibility of the RCM (Resident Care Manager). Staff member D stated she was not involved in QAPI but stated she has been working on a new cycle of nutrition with the kitchen. During an observation on 7/16/25 at 5:15 p.m., resident #5 was in the dining room for evening meal. During an observation on 7/17/25 at 7:32 a.m., resident #5 was in the dining room for morning meal. At 7:55 a.m. the resident was served coffee. At 8:01 a.m. the resident was served his food, ate independently, and appeared to be eating slowly. During an interview on 7/17/25 at 8:51 a.m., staff member E stated resident #5 was supposed to eat in the unit dining room. Staff member E stated the resident was resistant to getting out of bed. Staff member E stated the resident’s daughter wanted him up for meals. Staff member E stated the resident was previously a one to one for supervision while eating but was now under in-sight supervision only in the dining room. Staff member E stated the dietician did bring up weight loss as a concern. She stated the resident had some problems eating and swallowing. Staff member E stated the resident had speech therapy because of difficulty swallowing. Staff member E stated the resident was doing much better with eating and feeding himself when he was up out of bed and in the dining room. During an interview on 7/17/25 at 9:25 a.m., staff member MM stated resident #5 was supervised for meals. Staff member MM stated the residents’ meals were in between minced (finely chopped) and moist (foods that are soft and moist) diet textures. Staff member MM stated the resident used to be a one-to-one assist for meals but now was in sight supervision while in the dining room. Staff member MM stated the resident was working with Speech Therapy. During an interview on 7/17/25 at 10:01 a.m., Staff member B stated the residents were assessed on admission for nutrition concerns. Staff member B stated the dietitian was involved to evaluate interventions, implement interventions, communicate with family, and educate the staff. Review of resident #5’s weight record showed the resident weighed 132 lbs., on 6/9/25 and 120 lbs., on 7/12/25, which is a 9% severe weight loss in one month. Review of resident #5’s Nutrition/Dietary Progress Note, dated 6/10/25, showed staff member D was “unable to meet with the resident due to the flooring crew blocked the room. The resident was added to the NAR program due to severe weight loss in three months.” (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of resident #5’s Nutrition/Dietary Progress Note, dated 6/23/25, showed staff member D and staff member E met and discussed the resident’s worsening pressure wound to his right foot. The plan was to add Juven meal supplement two times daily for wound healing. Review of resident #5’s Nutrition/Dietary Progress Note, dated 6/24/25, showed the resident was to have weekly weights. The resident was followed due to malnutrition diagnosis. Review of resident #5’s Nutrition/Dietary progress note, dated 7/10/25, showed the resident required supervision and cueing during meals. The resident was documented as nutrition at risk (NAR) and was in the program due to a malnutrition diagnosis and wounds. 2. During an observation on 7/14/25 at 4:15 p.m., resident #87 was lying in bed with oxygen on. Resident #87 appeared thin and frail. Resident #87’s skin color was pale. Three unopened sugar free Boost containers were sitting by the television. During an interview on 7/15/25 at 8:08 a.m., resident #87 stated he was terminal and had a decrease in his appetite, but the facility was providing him with Boost at mealtimes. Resident #87 stated he does not always drink them. During an interview on 7/16/25 at 3:10 p.m., staff member D stated all residents who were new admissions were to be weighed weekly for four weeks to help establish a baseline weight. Staff member D stated the weights were documented in the medical record. Staff member D stated sometimes residents would refuse to be weighed but the refusal should also be documented in the medical record. Review of resident #87’s weight documentation from 6/27/25 to 7/17/25, showed a weight of 173.4 pounds on 6/27/25. No other weights were documented in resident #87’s electronic medical record. Review of a facility document titled, “Weight/Nutrition at Risk, BH320,” with an effective date of 3/2025, showed: “Policy 1. All patients/residents will be weighed on admission… and weights will be obtained weekly x 4 weeks and then monthly thereafter…”

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure a resident was provided tube feeding without complications to maintain his weight for 1 (#69) of 2 sampled residents for tube feeding. Findings include:During an observation on 7/15/25 at 8:25 a.m., resident #69's doorway had an enhanced barrier precaution sign posted. Resident #69 was in his recliner with his feet up and had his call light on. A tube feeding was hanging on a pole behind a bedside table with a suction machine on top of it. An unidentified CNA entered the room and resident #69 stated his tube feeding was leaking again. The unidentified CNA left to get staff member NN. Both the CNA and staff member NN entered the room. Neither staff member put on PPE other than gloves. The unidentified CNA cleaned up the leaked tube feeding and dumped the suction container into the sink and placed the container back on the bedside table. Staff member NN cleaned the tube feeding off resident #69's abdomen. She then adjusted the lock on the tube feeding where it was attached to the resident.During an interview on 7/15/25 at 8:44 a.m., staff member NN stated resident #69's tube feeding had just started, and it was locked so the pressure from the machine running had caused it to open and leak. Staff member NN stated she went into the resident's room, cleaned up the tube feeding that had leaked, then she unlocked the clamp so the tube feeding would administer.During an interview on 7/16/25 at 3:15 p.m., staff member D stated she had realized there was no more Isosource tube feeding bags when she saw the empty shelf in the kitchen. Staff member D stated she did not have a role in ordering supplies and could not write orders for diet or tube feeding supplements. Staff member D stated she informed the units they would need to temporarily use a different tube feeding formula and wrote progress notes for the substitution. Staff member D stated the alternate formula had been used for all residents receiving tube feeding for the last two days. She stated they were out of Isosource, and the current formula being used did not have the same caloric nutrients as the Isosource.During an interview on 7/17/25 at 9:17 a.m., staff member HH stated, he ordered to a par level of six for the Isosource 1.5 tube feeding formulas, but he had no way of knowing how many were needed in a day and it varied. Staff member HH stated he had Isosource ordered but the construction in front of the distributor blocked their route and delayed the shipment. He stated he doubled the order and was told it would be delivered that afternoon.During an interview on 7/17/25 at 10:50 a.m., staff member F stated the unit was told to substitute the Fibersource and it was supposed to be only substituted for one tube feed for the resident. She stated the Isosource was again delayed, so they had been using the Fibersource until the Isosource was delivered. Staff member F stated there was no new physician order for the change in the tube feeding. Staff member F stated staff member D came to the unit to inform the nursing staff of the delay in the Isosource delivery. She stated the kitchen staff had delivered the alternate tube feeding formula.Review of resident #69's physician orders, for his tube feeding, showed he was to be given Isosource 1.5. The TAR showed Isosource had been given when it was not available on 7/15/25 and 7/16/25. There were no new orders for the temporary change of the tube feeding formula from Isosource to Fibersource. The resident's orders showed the physician was not notified of the change in tube feeding formula. There was an order added for daily weights for two days entered on 7/15/25. As of 7/17/25, no weights had been documented. Review of resident #69's progress notes showed:- Nutrition Note on 7/14/25, No nutrition concerns at this time. Tolerating enteral nutrition at goal rate. Followed by NAR program. Diet Isosource 1.5. No significant weight loss in 1 or 3 months. No 6-month weight history.- Nutrition Note on 7/15/25, Kitchen is out of Isosource 1.5. Provide Fibersource HN at ordered rate until Isosource 1.5 is back in stock. RD to continue to monitor.Review of resident #69's weight on 3/10/25 showed 160 lbs. On 3/31/25 his weight was 149.5 lbs. There was a 6.65% weight loss between 3/10/25 and 3/31/25. A review of the weights for July 2025 showed no weights were documented in the EHR for the resident. Review of the facility policy, Adult Confirmation and Management of Feeding Tubes/Nasogastric Tubes, AGN470, last revised 5/25/25, showed, Patient weights should be obtained Monday, Wednesday, and Friday.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brendan House	350 Conway Dr Kalispell, MT 59901

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility licensed nursing staff failed to ensure a physician's order was in place for a resident's oxygen use, for 1 (#87) of 3 sampled residents for oxygen use. Findings include:During an observation on 7/14/25 at 4:15 p.m., resident #87 was lying in bed with oxygen on via nasal canula, and the oxygen concentrator was set to 1.5 liters.During an interview on 7/15/25 at 8:08 a.m., resident #87 stated he had a diagnosis of lung cancer that had spread, and he was terminal. Resident #87 stated he used oxygen all the time.During an interview on 7/18/25 at 8:35 a.m., staff member E stated that nursing staff were responsible for getting orders from the physician. Staff member E stated it was her expectation for nursing staff to notify the physician of any changes and get the physician's orders needed, and if oxygen is needed, the nursing staff should let the physician know right away and get the corresponding order.Review of resident #87's physician's orders, dated 6/27/25-7/14/25 showed no orders for oxygen use.Review of a facility document titled Adult Oxygen Therapy at [Facility Name], BH243, with a revision date of 6/2023, showed:. Initiation of Oxygen1. Oxygen therapy will only be initiated by provider order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to provide food at an appetizing temperature for 1 (#47) of 6 sampled residents for nutrition; and failed to ensure kitchen staff were wearing hair restraints, or wearing them properly, during food preparations. This deficient practice had the increased the risk of food borne illnesses for those who received meals in the facility. Findings include:1. During observations and interviews on 7/14/25 at 4:19 p.m., this surveyor was escorted into the kitchen by staff member CC through open double doors in the propped open position; no signage requiring hair coverings was noted; staff member CC walked approximately ten feet into the kitchen without a hair restraint, and was asked if she needed a hair net, her reply was, “Do I need a hair net?” Staff member DD was preparing dinner plates with her hair in a bun and a hat on; the hair by both of her ears had fallen out and was not restrained. Staff member EE was preparing dinner plates with a hair net on which did not restrain her hair from her forehead back approximately three inches. During observation and interviews on 7/15/25 at 12:49 p.m., staff member FF was preparing raw bacon on a cookie sheet pan with no beard covering. Staff member HH stated he did not know the exact hair covering policy. During an interview on 7/17/25 at 9:05 a.m., both staff members GG and JJ stated they were aware of staff not wearing appropriate hair restraints, and it was difficult to monitor because of the high turnover rate. During an observation on 7/17/25 at 9:05 a.m., the front portion of staff member KK’s hair was not covered completely by her hair net and staff member KK stated, My hair is struggling today. Yes, I am supposed to cover all my hair with the net. During an interview on 7/17/25 at 9:10 a.m., staff member GG stated there were hats available for staff who needed help to restrain their hair when a hair net was not enough. Staff member GG stated everyone who works in the kitchen should be supervising hair restraints. Staff member GG stated the main double doors were always propped open to the kitchen. Staff member GG stated she had a sign posted reminding people to restrain hair with nets before entering the kitchen, and stated, “I took them down two weeks ago because people get used to the postings and don’t see them anymore.” Review of a facility policy titled, Uniform Policy, revised 8/24, reflected: . 2. Hair Covering; Hats/hair covering will be worn at all times. a. Shall wear hair covering that will cover all hair…needs to be contained in a hair covering or above the collar, this may be a hair net, Logo [facility] caps or bonnet…” 2. During an observation on 7/15/25 at 7:45 a.m., resident #47 was lying in bed, asleep. Staff member U picked up resident #47’s breakfast tray, took the meal tray into resident #47’s room and set it on the bedside table, and left the room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview at 7/15/25 at 10:50 a.m., resident #47 was sitting at a table in the dining area eating breakfast. Resident #47 stated her breakfast was put in the microwave and given to her. Resident #47 stated it was not very good and cold in some areas. During an interview on 7/15/25 at 11:02 a.m., staff member U stated meal trays arrived between 7:30 and 7:45 a.m. Staff member U stated if a resident is not awake or up, the meal tray is delivered to the room. Staff member U stated, “When she (resident #47) wants her food we will reheat it for her.” Staff member U stated she did not know there were specific timelines or temperatures with food. Staff member U stated she had never used a thermometer to test food temperature after reheating the meal in the microwave. Staff member U could not verbalize how long a tray could sit out before it was unable to be eaten, or at what temperature the food should be heated to upon reheating. During an observation on 7/16/25 at 8:55 a.m., staff member R placed resident #47’s meal tray in front of her, took off the lid and buttered the waffle. The butter did not melt on the waffle. During an interview on 7/16/25 at 8:58 a.m., resident #47 stated her breakfast was cold and the waffle was tough. Resident #47 stated, “It would be better warm.” During an interview on 7/16/25 at 3:10 p.m., staff member D stated, “Food should not be served to a resident after two hours, anything longer than that is unsafe.” Staff member D stated it was not a standard of practice for nursing staff to be reheating or microwaving food. Staff member D stated, “If a resident is not going to eat right away the tray should go into the refrigerator or staff request a whole new tray when they are ready to eat.” Staff member D stated there was thermometers and food risk information on each unit. During an interview on 7/16/25 at 4:10 p.m., staff member N stated he had never seen a thermometer or food risk information on the unit. During an interview on 7/17/25 at 8:35 a.m., staff member E stated staff should not be reheating food for residents. Staff member E stated there was not a thermometer or food risk information on the unit. Review of a facility document titled, “Food Production Standards,” with an effective date of 5/2025, showed: . 5. Reheating of foods a. Food must be reheated to 165 degrees for 15 seconds within two hours. b. Do not mix leftover food with freshly prepared food. 6. If food is not handled as in above, throw it out.”

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff adhered to standards of practice for infection control by not using proper hand hygiene and glove changes during wound care for 2 (#s 5 and 60), and failed to use proper infection control practices for 2 (#s 5 and 69) of 13 sampled residents for infection control by not adhering to practices for Enhanced Barrier Precautions by not wearing a gown during wound care, suctioning, and tube feeding. This deficient practice had increased the risk of the spread of infection for all residents in the facility. Findings include: 1. During an observation and interview on 7/16/25 at 11:11 a.m., staff member I performed a dressing change on resident #5's right heel. Staff member I donned clean gloves and removed the soiled dressing. The dressing was saturated with yellow exudate, and slough was covering the wound. Staff member I did not change gloves or sanitize hands between removing the dressing and applying the clean dressing. The wound was not cleansed prior to putting the clean dressing on. Staff member I stated wound care orders were usually on the TAR, but she did not see any orders for wound cleansing. The wound was covered with Aquacel and wrapped in Kerlix. Staff member I did not remove her gloves before departing the resident's room. The resident was on EBP (Enhanced Barrier Precautions) which required gloves and gown for high contact ADLs and catheter cleaning. Staff member I did not wear a gown during the procedure. During an interview on 7/17/25 at 9:58 a.m., staff member B stated there was a policy for wound care and the staff were expected to follow wound orders. The wound was assessed upon admission, and the provider was contacted for orders for wound care. Staff were to follow physician orders for wound care, including cleansing and proper infection control practices. Staff member B stated the staff were to follow infection control policies for wound care. Staff member B stated the facility had recently completed pressure ulcer training including training on infection control practices. Review of the facility policy titled, “Hand Hygiene,” showed: . “All employees must achieve full compliance with the hand hygiene standards outlined in this policy and procedure… when to perform hand hygiene . Immediately before each episode of direct patient contact/care, including clean/aseptic procedures . immediately after each episode of direct patient contact/care . immediately after the removal of gloves, including between the exchange of dirty to clean gloves . before and after handling/administering medicines . after removing personal protective equipment . standard aseptic non touch technique such as wound care . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 7/15/25 at 8:25 a.m., resident #69's doorway had an enhanced barrier precaution sign posted. Resident #69 was in his recliner with his feet up and had his call light on. A tube feeding was hanging on a pole behind a bedside table with a suction machine on top of it. An unidentified CNA entered the room and resident #69 stated his tube feeding was leaking again. The unidentified CNA left to get staff member NN. Both the unidentified CNA and staff member NN entered the room. Neither staff member put on PPE other than gloves while the unidentified CNA cleaned up the leaked tube feeding and dumped the suction container in the sink and placed the suction container back on the bedside table. Staff member NN cleaned up the tube feeding that was on the resident’s abdomen. She then adjusted the lock on the tube feeding where it was attached to the resident. During an observation on 7/16/25 at 11:14 a.m., staff member OO entered resident #69’s room, donned gloves and connected the resident’s tube feeding and took the end of the suction off due to it falling on the ground. Staff member OO did not don a gown. During an interview on 7/17/25 at 10:43 a.m., staff member F stated when providing cares for suction or tube feeding staff were expected to wear gowns and other PPE. The suction should be emptied in the toilet and rinsed out before replacing it back on the device. 3. During an observation on 7/15/25 at 10:45 a.m., staff member Q started wound care on resident #60. Resident #60 had wounds to his bilateral lower extremities. Staff member Q donned a gown and gloves prior to entering resident #60’s room. After staff member Q donned the person protective equipment, she knocked on the door to resident #60’s room and opened the door. Staff member Q did not change her gloves after touching the door and entering the room. Staff member Q opened the xeroform package and placed the xeroform on to the wound located on the right lower extremity. Staff member Q opened two ABD packages and placed the ABDs over the Xeroform. Staff member Q removed her left glove and replaced it with a new glove. No hand hygiene was performed prior to replacing the left glove. Staff member Q wrapped the area in Kerlix (gauze). Staff member Q opened another Xeroform package and placed the Xeroform to the wound located on the left leg. Staff member Q doffed her glove and gown and left the room. No hand hygiene was completed prior to or after exiting the room. Staff member Q entered the supply area and retrieved more supplies for resident #60. Staff member Q walked over to the medication cart, placed the supplies on top of the medication cart and went back into the supply area. Staff member Q exited the supply closet went back to the medication cart touched the top and the sides of the medication cart and picked up the supplies. Staff member Q walked back to resident #60’s room donned a new gown and gloves and entered the room. No hand hygiene was completed prior to donning the gown and gloves. Staff member Q opened the two ABD packages and placed ABD pads to the wound located on the resident’s left lower extremity. Staff member Q opened the Kerlix (gauze) and placed it on the bed with resident #60, while she moved a pillow, and moved a blanket and a stuffed animal away from resident #60. No glove change or hand hygiene was completed after contaminating the glove. A new roll of Kerlix was not retrieved after contaminating the Kerlix on the bed. Staff member Q wrapped the wound in the Kerlix. Staff member Q doffed her gown and gloves in the trash, tied the trash bag and left the room. Staff member Q walked through the dining area with trash, entered the soiled utility room and disposed of the trash. No gloves were donned while handling the trash, and no hand hygiene was performed after disposing of the trash. Staff member Q walked over to the medication cart and grabbed a medication card. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/25 at 11:25 a.m., staff member Q stated hand hygiene was to be performed prior to entering and exiting resident’s rooms, before and after resident care, after doffing any personal protective equipment, and when your hands become soiled. Staff member Q stated, “I should have done more hand hygiene during wound care and after I was finished but I just didn’t think about it. ” Staff member Q stated she had been educated on infection control, hand hygiene, and enhanced barrier precautions. During an interview on 7/17/25 at 9:00 a.m., staff member K stated she provided the staff with infection prevention and hand hygiene education. Staff member K stated infection prevention education, including hand hygiene was done on hire and yearly. Staff member K stated if there was a concern or she had witnessed a concern she would provide in the moment education with staff, and if there continued to be concerns with a certain area it would be escalated to the managers. Staff member K stated the expectation for infection prevention and hand hygiene was for staff to follow the policies and to make sure they were using PPE appropriately and performing appropriate hand hygiene. A review of a facility document titled, “Hand Hygiene, ICP104,” with a revision date of 2/2025, showed: … “Policy 1. [Facility Name] recognizes hand washing as the most important health procedure any individual can perform to prevent the spread of microbes. 2. All employees must achieve full compliance with the hand hygiene standards…, Procedure: 1. Patients are put at risk for developing an HAI when the health care workers caring for them have contaminated hands. … Perform hand hygiene: A. Immediately before each episode of direct patient contact/care, including clean/aseptic procedures, B. Immediately after each episode of direct patient contact/care, D. After handling contaminated laundry and waste, F. Before and after leaving isolation rooms/bays.” Review of a facility document titled, “Enhanced Barrier Precautions Policy ICP326,” with a revision date of 5/2024, showed: … “Personal Protective Equipment (PPE) A. Gloves and gown are doffed into a garbage within the resident room after each resident encounter and hand hygiene is performed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Hand hygiene is performed between each resident after doffing.”[sic]

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure residents received, or had the opportunity to receive, the pneumococcal vaccine series for 2 (#s 1 and 87) of 5 sampled residents for vaccinations. Findings include:During an interview on 7/17/25 at 9:00 a.m., staff member K stated immunization information is collected on admission. Staff member K stated she collected the immunization requests or declinations weekly, and if a resident would like a vaccine, she would order it and provide it to the resident. Staff member K stated she was not sure why vaccinations were missed. Staff member K stated if a resident had a prior pneumococcal vaccine they were considered immune. Staff member K could not verbalize the current recommendations for pneumococcal vaccines in adults.1. Review of resident #1's vaccine consent form dated, 10/22/24, showed resident #1's representative consented to all immunizations to include pneumococcal.Review of resident #1s immunization documentation showed he had received pneumococcal 23 vaccine on 7/28/2016.The CDC (Centers for Disease Control) recommends the pneumococcal 20 or pneumococcal 21 for people who only received the pneumococcal 23 vaccine at any age, and it has been greater than one year since administration.(www.cdc.gov/pneumococcal/downloads/vaccine-timing-adults-jobaid.pdf)2. Review of resident #87's electronic medical record from 6/27/25 to 7/17/25, showed no vaccination history or vaccination consent.During an interview at 10:44 a.m., resident #87 stated he had not been asked about vaccinations upon admission.A request for resident #87's vaccination consent was requested on 7/17/25 at 7:55 a.m., and was not received prior to the end of the survey.The CDC (Centers for Disease Control) recommends the pneumococcal 20 or pneumococcal 21for people who have never had any pneumococcal vaccines.(www.cdc.gov/pneumococcal/downloads/vaccine-timing-adults-jobaid.pdf)Review of a facility document titled, Pneumococcal for Long Term Care Units, IPC216, with a revision date of 9/2024, showed: Policy: The facility will follow CDC recommendations on immunization for pneumococcal disease for those 65 years and older, or for those 19-64 with certain underlying medical conditions or risk factors. [sic]