

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Northern Montana Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 24 13th St Havre, MT 59501	
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 document required information for resident transfers/discharges for 2 (#s 76 and 78) of 21 sampled residents and failed to inform the Ombudsman's office of all resident transfers/discharges. Findings include: During an interview on 7/15/26 at 4:17 p.m., staff member F stated that when a resident would go on LOA or transfer to another facility, the floor nurse would fill out the same form for a transfer and/or bed hold and then mark the reason for leaving. The nurse would then fax the form to the admission department to hold the resident's chart. Staff member F stated the nurses were to have medications repackaged by the pharmacy for the LOA residents, but they did not document in the medical record information regarding the LOA or transfer. Once they (residents/chart) were placed on a hold, the nursing staff did not follow up unless the resident returned. Staff member F stated no documentation or assessment would be completed for a resident returning from LOA unless a resident specifically told them they had an issue while on LOA, and the resident returned any medications to be placed back in the medication cart. During an interview on 7/16/26 at 10:08 a.m., staff member A stated resident #76 had a bed hold in place as he wasn't admitted to another nursing home and he didn't discharge to his home. Staff member A stated resident #76 had no family, so it was a way to keep his belongings safe in case he returned to the facility. Staff member A stated even though resident #76 had been gone for over 40 days, he would have missed the time to complete a 30-day discharge notice since the resident was a bed hold until he left the hospital. Staff member A stated they would continue the bed hold as the facility had plenty of rooms available for a return. Staff member A stated that for a LOA such as with resident #78, there was no expectation for facility staff to document on the resident, as the form that was filled out showed they were out of the facility and their EHR would show the LOA warning if they tried to open it. Staff member A stated the facility charted by exception but had a process with the forms so nursing would not document for a LOA or bed hold. During an interview on 7/16/26 at 10:16 a.m., staff member D stated the facility EHR system placed resident #76 on LOA because the medical record did not differentiate between LOA and bed holds. There would be documentation showing 'hospital,' reflecting it was not a therapeutic LOA, or a LOA for resident #78 completing a trial stay at home. Staff member D stated resident #78 was private pay, and she didn't have a qualifying stay for Medicare A services. Staff member D stated resident #78's POA wanted the resident to have a trial stay at home before discharging just to make sure she was ready. If it went well, they would discharge after, and she discharged the same day she returned from LOA. Review of resident #76's EHR between 7/13/26 and 7/16/26, including the census, facility progress notes, and provider notes, showed the resident was admitted to the facility on [DATE] and transferred to the emergency department on 6/9/26. He was then transferred from the emergency room to another (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospital on 6/10/26, admitted to that hospital, where he remained as of 7/16/26. Resident #76's chart did not have documentation of an indefinite transfer or bed hold, or a recapitulation of stay, after 30 days out of the facility. Review of resident #76's census showed: Enter ADM Skilled Nursing Facility on 6/3/26, Enter LOA on 6/9/26 with the note of Hospital, Change Room/Bed on 7/1/26. Review of resident #78's facility progress notes, dated 5/6/26 to 5/12/26, showed her POA communicated to staff member D on 5/6/26 that they wanted the resident to have a trial weekend at home before discharging. Resident #78 was placed on LOA status on 5/8/26 and returned from LOA on 5/12/26 to discharge on [DATE]. Resident #78's family member communicated to the facility that she wanted resident #78 to be discharged on 5/11/26, and the facility communicated the provider was not available and would write a physician's order for the resident to discharge on [DATE]. Resident #78's progress notes did not include documentation of the required information for a discharge from the facility. During an interview on 7/15/26 at 2:20 p.m., NF1 stated the Ombudsman's office received no regular transfer or discharge notices for residents staying at the facility unless there was an involuntary discharge. Review of resident #78's medical record, under the census, showed: Enter admin Skilled Nursing Facility on 4/16/26, Enter LOA on 5/8/26 with a note of Home, End LOA on 5/12/26 at 12:30 p.m. with a note of Home; and, Discharge Skilled Nursing Facility on 5/12/26 at 12:30 p.m. Review of resident #78's medical record face sheet showed the payor source as Medicare AB and private insurance. Review of resident #78's form titled Financial Responsibility Statement, signed 4/16/26, showed the payor source selected was the resident's own financial resources and long-term care insurance. Review of the facility policy titled Bed-Hold Notice/Discharge/Readmit/Transfer, last reviewed 6/13/25, showed: . C. Nursing staff shall document the reason for a transfer and notify the family of the transfer. Resident's Temporary Hospitalization. G. [Facility] shall maintain, and upon request, provide to the State, documentation that the absence is expected to be temporary and the anticipated duration of the absence. Temporary absences of indefinite duration must be documented at least weekly by nursing or a physician to assure that the absence is indeed temporary. Review of the facility policy titled, Interdisciplinary Discharge Process, last reviewed 6/13/25, showed: .5. Interdisciplinary Discharge plan shall include the following: . e. instructions. pertinent information regarding individual diagnosis. 6. [Facility] shall complete a summary of information about the resident upon discharge to home or other community-based service. This shall provide continuity of care to the resident & responsible, authorized parties. The interdisciplinary discharge summary shall be documented in Meditech. Each respective discipline shall access the Discharge Summary to document in prospective areas. 3. The nurse is responsible for entering information into the Discharge Summary. 4. When a potential discharge date or time has been identified, the social worker or designee shall contact the provider and notify him or her of the potential for discharge. The provider may choose to see the resident prior to his/her going home. 10. The Discharge Packet shall be reviewed with the resident/designee. The signatures of the resident/designee and of the nurse reviewing the plan are required. Place the signed copy in the chart and send a copy with the resident as discharge instructions. 11. A copy of the Discharge Packet shall be given to the resident/designee along with his or her packaged medication(s) and any special equipment received upon discharge. 12. The discharging nurse shall enter a note giving the date and time of discharge accompanied by the method of discharge (i.e., ambulatory, by wheelchair or by stretcher). [Facility] shall complete a summary of information. 2. The summary shall be complete prior to or on the day of discharge.		

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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 complete a Discharge Minimum Data Set Assessment for a resident who passed away in the facility for 1 (#67) of 24 sampled and supplemental residents. Findings include: Review of resident #67's discharge summary with a date of 2/20/26 showed: . Narrative: Patient passed peacefully with her family by her side. Review of resident #67's electronic medical record showed: Minimum Data Set Assessment list: Tracking entry MDS with an accepted date of 2/12/26 had been completed. Comprehensive MDS with an accepted date of 2/19/26 had been completed. The electronic medical record failed to show that a Tracking (Death record) MDS had been completed after resident #67 passed away. During an observation and interview, on 7/15/26 at 4:12 p.m., staff member G was on her computer and looked up resident #67's MDS records. Staff member G stated she could see the entry MDS had been done on 2/5/26 and stated, That was her Assessment Reference Date. Staff member G stated resident #67's Comprehensive admission MDS was completed on 2/14/26. Staff member G stated resident #67 passed away in the facility on 2/20/26, and a death in facility MDS had not been completed. Staff member G stated her process for completing MDS assessments was to submit MDS submissions every Thursday after staff completed their IDT review meeting. Staff member G stated, I just missed this one, and I don't know why. Staff member G stated, I will get it submitted right now. The Death in Facility Discharge MDS was 118 days late. Review of a facility document titled Minimum Data Set (MDS) with a revision date of 6/16/25 showed: Policy: The Resident Care Coordinator/designee shall complete assessments of all residents at the Care Center using the Resident Assessment Instrument (RAI) format. Purpose: To ensure that the RAI is used in conducting comprehensive assessments as part of an ongoing process through which the facility identified the resident's functional capacity and health status. 3. Information needed to complete MDS/CAA/[NAME] can be obtained from any pertinent assessment/intervention in resident record, or interview of resident, family, or providers.		

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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 administer an influenza vaccine for 1 (#12) of 5 sampled residents for vaccinations. Findings include:Review of the vaccination consent/declination form, signed on 10/31/25, showed resident #12's POA consented to receiving the influenza vaccine.During an interview on 7/18/26 at 8:06 a.m., staff members A and C stated resident #12 did not have documentation of receiving an influenza vaccine the resident consented to on admission. Staff member C stated she had not been working at the time. Staff member A stated the consent was found in the paper completed filings, but the resident's medical record did not show an actual administration of the vaccine.Review of resident #12's EHR on 7/16/26, did not show an actual administration of the influenza vaccine on admission. The facility had no evidence the vaccine was provided to the resident.		