STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275119	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan Health - Conrad	805 Sunset Blvd Conrad, MT 59425

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to accurately complete the active diagnoses section of the MDS for 1 (#1) of 17 sampled residents. Findings include:During an observation and interview on 5/5/26 at 8:28 a.m., resident #1 was observed to have a dry, hacking cough, but no obvious shortness of breath. Resident #1 denied being admitted to the hospital or being treated for any respiratory illness.Review of resident #1's EHR, accessed on 5/6/26, showed a pneumonia diagnosis was present at the time he was admitted to the facility in May of 2025. The resident's EHR failed to show any hospital admission since May of 2025.Review of resident #1's Quarterly MDS assessment, with an ARD of 2/22/26, showed an active diagnosis of pneumonia.During an interview on 5/6/26 at 9:50 a.m., staff member C stated resident #1 had pneumonia at the time he was initially admitted to the facility in May of 2025. Staff member C stated she should have deleted the pneumonia diagnosis when the resident completed the treatment and had fully recovered from the illness.

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, and record review, the facility failed to ensure an appropriate indication was given for the use of an antipsychotic medication for 1 (#7) of 17 sampled residents. Findings include:During an observation on 5/4/26 from 6:00 p.m. to 7:00 p.m., resident #7 was sitting at a table with two male residents. Resident #7 finished what was served for dinner and told staff she was still hungry. Staff provided a sandwich for the resident. The resident did not display any disruptive behavior during the dinner observation.Review of resident #7's physician order, dated 11/21/25, showed the resident was receiving olanzapine (anti-psychotic medication) 2.5 mg daily for a diagnosis of, F03.90 Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.During an interview on 5/6/26 at 1:45 p.m., staff member C stated she was responsible for ensuring pharmacy reviews and recommendations were completed. When asked about the use of an anti-psychotic medication (olanzapine) for a resident (#7) without behavioral disturbance, staff member C stated she had not noticed resident #7's most recent order for olanzapine (11/21/25) had a diagnosis that identified no behavioral issues. Staff member C stated, I know we can't use anti-psychotic medications if there are no behaviors. Staff member C did not know why this discrepancy was not identified.During an interview on 5/6/26 at 3:00 p.m., staff member E stated the discrepancy with the resident's diagnosis of dementia without behavioral disturbance was identified in March of 2026 during an IDT meeting. Staff member E stated the diagnosis was corrected on the resident's diagnosis list in the EHR. Staff member E did not know why the order for olanzapine, dated 11/21/25, did not have the correct indication for the use of an anti-psychotic medication for a resident with dementia. Staff member E stated the diagnosis list should match the medication order, and she could not explain why this discrepancy had been missed.During an interview on 5/7/26 at 9:43 a.m., staff member I stated that when resident #7 was initially admitted from an assisted living facility in May of 2025, the resident was demonstrating exit-seeking behaviors and anger towards the staff when she was not allowed to leave. Staff member I stated resident #7 was started on olanzapine while still at the assisted living facility. Staff member I stated the olanzapine was continued after admission due to her continuing behaviors. Staff member I stated the diagnosis of dementia without behaviors was from a previous admission in 2023. Staff member I stated he must have missed the discrepancy in the diagnosis, and it should have been dementia with behaviors. Staff member I stated the reason the olanzapine was being given was to control resident #7's exit seeking behaviors and anger.Review of the facility's policy titled, Pharmacy Medication Regimen Review, dated September 2025, showed, Pharmacist Medication Regimen Review (MRR) . c. The MRR may include, but is not limited to: . b. Evaluate medication for appropriate dose, indication, duration, .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to discard expired food, and failed to properly date, label, and store food in the main kitchen freezer and cooler. These failures had the potential to affect all residents consuming food in the facility. Findings include:During an observation of the kitchen and interview with staff member G on 5/4/26 at 4:11 p.m., the dry storage area had two cups of instant oatmeal which expired on 3/11/26 and five boxes of instant cream of wheat which expired on 4/1/26. The cream of wheat boxes contained 10 packets each. There was also a 28-ounce box of creamy wheat which was open to air and not dated. The meat freezer was found to have a plastic bag containing some type of breaded meat product (possibly chicken tenders), a bag of breaded meat patties (possibly chicken), and a plastic bag containing beef patties. These three bags were open to air and not dated when received or opened. The vegetable cooler had an open bag of leaf lettuce which was not dated when received or opened. Staff member G stated she had been in her current position for one month. Staff member G stated she was aware all open items needed to be dated and that food needed to be discarded by their use by date or their expiration date. During an observation on 5/7/26 at 9:31 a.m., the three bags in the meat freezer and the bag of leaf lettuce were still present, open to air and not dated when opened.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to maintain documentation of the COVID-19 vaccination status (received or refused) for staff member F, out of those staff sampled for the received/refused COVID-19 vaccination tracking. Findings include: Review of staff member F's COVID-19 vaccination status, dated 5/6/26, showed the staff member had signed the declination on 5/6/26.During an interview on 5/6/26 at 10:42 a.m., staff member F stated he had been asked about getting the COVID-19 vaccination when he initially started at the facility (August of 2025). Staff member F stated he signed the declination form earlier on 5/6/26.During an interview on 5/7/26 at 8:59 a.m. staff members C and D stated staff member B was currently responsible for staff COVID-19 status documentation.Review of the facility's policy titled, COVID-19 Vaccination Program, 84.05.2021.OP.118, dated February of 2025, showed, Screening will be ongoing and allow for employees/residents who have initially declined, to receive the vaccine at a later date. The Infection Control Coordinator or designee will maintain surveillance data on COVID-19 vaccine coverage among employees/residents.