STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Billings Rehabilitation and Nursing LLC	600 S 27th St Billings, MT 59101

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 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. 48261 Based on observation, interview, and record review, the facility failed to cover catheter bags for 2 (#s 2 and 24) of 29 sampled residents, and staff were aware the covers should be utilized for resident dignity, and one resident was not ok with the bag being uncovered. Findings include: 1. During an observation on 2/25/25 at 11:13 a.m., resident #2's catheter bag was attached to the bed and not covered with yellow urine in the bag. During an observation and interview on 2/25/25 at 11:24 a.m., resident #2 was in her room with the curtain pulled. Resident #2's catheter bag was hanging from the bed and not covered, with urine in the bag. When asked about her catheter bag, resident #2 stated, I just figured that was how the bag was supposed to be, I didn't know there was another option. 2. During an observation and interview on 2/24/25 at 2:30 p.m., resident #24 was in bed resting, her door was open, and the catheter bag was exposed, with urine in the bag. The catheter bag was hanging from her bed. Resident #24 stated she was not okay with her catheter bag being exposed. During an interview on 2/26/25 at 3:54 p.m., staff member F stated catheter bags should be covered for dignity. During an interview on 2/26/25 at 4:11 p.m., staff member G stated the catheter bag covers should be on all catheter bags for dignity, but CNAs do not always take the time to go find them. During an interview on 2/26/25 at 4:26 p.m., staff member H stated, We are supposed to keep the catheter bags covered (for dignity). A request was made on 2/26/25 at 11:09 a.m., and again on 2/27/25 at 12:40 p.m., for a policy and procedure for catheter care, to include catheter bags and was not received by the end of the survey.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 52362 Based on observation, interview, and record review, the facility failed to supervise the self-administration of insulin for 1 (#29) of 29 sampled residents. This deficient practice increased the risk of a negative outcome if the resident in the event the medication and monitoring were not handled properly by the resident. Findings include: During an interview on 2/24/25 at 7:53 a.m., resident #29 stated he gave his own insulin and monitored his own blood glucose levels. When asked if the nurses watched him administer his insulin, resident #29 stated, No, I do it myself and have for years. During an observation and interview on 2/26/25 at 8:05 a.m., resident #29 demonstrated how his continuous glucose monitoring system worked with the arm sensor he wore and the app on his mobile phone. Resident #29 stated, I tell the nurses what my blood glucose was when asked by the nurses. During an interview on 2/26/25 at 8:52 a.m., staff member G stated resident #29 should have had a self-administration of medication assessment, but was not sure where to find it. Staff member G stated she did not observe resident #29 self-administer his insulin; and, . he has always given his own insulin without help. During an interview on 2/26/25 at 10:16 a.m., staff member D stated there was an assessment the facility gave residents who wanted to self-administer medications. The resident would demonstrate and explain how they gave their own medications to a nurse. Residents who self-administered medications had lock boxes in their room. Staff member D stated there was no form the facility documented this assessment on, but, . the resident's should be checked quarterly if they are able to self-administer medications. During an interview on 2/26/25 at 4:19 p.m., staff member B stated the facility did not have resident #29's self-administration of medication assessment. Review of resident #29's Medication Self-Administration Safety Screen, dated 04/18/24, reflected, Resident may self-administer medications WITH SUPERVISION. [sic] Review of the facility's policy titled Self-Administration of Medications, revised December 2012, showed, . 10. The staff and practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications. [sic]

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48261 Based on observation, interview, and record review, the facility failed to complete maintenance services necessary to maintain a clean, safe, and sanitary environment for 3 (#s 28, 29, and 72) of 29 sampled residents. Two residents, #s 28 and 29, were aware and not happy about the concerns identified in their rooms. Findings include: 1. During an observation and interview on 2/25/25 at 9:40 a.m., resident #28 was resting in her bed, with her face against the wall, on her left side. Resident #28's wall had an approximately four inch wide by 12-inch-long tear in the sheetrock. The powdered sheetrock was exposed, and there appeared to be digging marks in the sheetrock. Resident #28 stated, That wall's a mess, they need to do something about it. In the bathroom, the paint was peeled away around the toilet, leaving an uncleanable surface. 2. During an observation and interview on 2/25/25 at 8:27 p.m., resident #72 was in bed sleeping. A hole in the white floor linoleum approximately 12 inches long by five inches wide was noted on the floor of the bathroom, to the left of the toilet. The linoleum edges were worn down and had turned a brown/yellow color from wear. There were five areas in the sheetrock, approximately two inches by two inches, where sheetrock was exposed creating an uncleanable surface. During an interview on 2/26/25 at 4:11 p.m., staff member G stated requests for repairs should be entered in the Maintenance Request logs, when concerns were found by staff. Review of the Maintenance Request logs, dated 10/28/24 to 2/27/25, reflected no requests for wall or floor repairs for resident #28 or resident #72's wall damage or floor damage. 52362 3. During an observation on 2/24/25 at 3:38 p.m., resident #29's room appeared dirty and cluttered, the floor had stains, and there were open and closed food containers (outside and facility provided food), including a bag of molded green grapes. The drywall next to resident #29's bed had cracks and marks, one electrical outlet cover was broken, an untouched food tray was sitting on the mattress, and the fitted sheet on the mattress was dirty with food crumbs, stained with a pink substance, and threadbare, with a three inch by three inch opening. During an observation and interview on 2/25/25 at 7:53 a.m., resident #29's room had the same soiled threadbare fitted sheet on his mattress as noted on 2/24/25, as well as the same food containers; the moldy grapes were removed. Resident #29 stated housekeeping came every day to clean his room. Resident #29 stated the last time his sheet had been changed was about two to three weeks prior. Resident #29 stated the dirty sheet made him feel, bummed out. During an interview on 2/26/25 at 8:09 a.m., resident #29 stated he was getting tired of looking at the dirty sheet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 8:17 a.m., staff member P stated resident rooms were cleaned seven days a week, unless a resident did not want it, but at least every other day. Staff member P stated she respected resident #29's request to not throw away food found on the floor, unless it was spoiled. Staff member P stated the stains on the floor of resident #29's room would be deep cleaned when he moved out, and, . the buffer machine may help, but I forget to reach out to other departments. Staff member P stated if anything needed fixed, she would put it in the maintenance log or let the maintenance staff know. Staff member P stated she could also change a resident's sheets, . it's not always the CNAs duty. Staff member P stated she tried to clean resident #29's room when he was in dialysis. During an interview on 2/26/25 at 9:09 a.m., staff member E stated he was only in the facility three days a week, and it was hard to keep up with the maintenance work that needed to be done. Staff member E stated the rooms were not always empty to be able to work on them, and he had to wait until Administration and Nursing told him he could. Staff member E stated facility walls got damaged because the staff pushed resident beds up against the walls. Staff member E stated he could not sand and paint resident #29's walls, . hopefully I can get in there when he moves out. Staff member E stated he knew about maintenance needs when staff told him, but then he would forget, so he audits rooms once a month. During an interview on 2/26/25 at 9:30 a.m., staff member L stated resident #29 did not like to have his room cleaned, but if the food containers were open or gross, she cleaned it up. Staff member L stated resident sheets were changed a couple of times a day, or at least once a day, if possible. Staff member L stated it would be gross if a resident had to sleep in a dirty sheet. Staff member L stated she had not been in Hall E for over two weeks, and, . I have a lot of catching up to do. Staff member L stated she would let the nurse or maintenance staff know when something needed to be fixed in a resident's room. During an interview on 2/26/25 at 10:27 a.m., staff member Q stated his expectations for completion of necessary resident room repairs was eight days; and, . if we see it in the maintenance book then it gets done, but I've only worked in this facility for eight days. Staff member Q stated he had not been in resident #29's room yet to identify any issues. Staff member Q stated managers would section out six resident rooms every morning to audit, and they would switch the rooms between managers, for the audits. Review of the facility's maintenance request log, from 9/8/24 to 2/25/25, reflected no documentation of a maintenance request to fix resident #29's wall, electrical plate, or stained floor. Review of the facility's policy titled, Maintenance Service, revised December 2009, showed: . 2. Functions of maintenance personnel include, but, are not limited to: b. Maintaining the building in good repair and free from hazards.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 49554 Based on observation, interview, and record review, the facility failed to complete a thorough investigation for an event with a staff member accepting money from a resident, in exchange for craft items, for 1 (#41) and failed to identify missing items for 2 (#s 37 and 280) of 29 sampled residents. Residents #37 and #280 were frustrated and concerned about the missing items, and resident #41 was upset and worried about a staff member accepting money from a resident. Findings include: 1. During an observation and interview on 2/24/25 at 4:05 p.m., resident #41 was in her room; her room was full of crafts and puzzles she had completed or was working on. Resident #41 stated, I'm worried about saying anything; I'm afraid of retaliation. I have had some issues with a staff member, and she still works on my hall. I have told the previous administration about this issue, and nothing was done. Staff member U brought in some craft stuff for me to look through. I thought she brought it in for me to use. I picked out what I wanted and then offered to pay a little bit. Staff member U said, okay, you can pay for the resin. Then she started tallying up the other items; before I knew it, she was at nearly fifty dollars. I paid her, and then she stated, Do you have unlimited funds? I stated no, and then I reported it to the administrator . During an interview on 2/25/25 at 4:49 p.m., staff member B stated activities was responsible for coordinating with the business office manager to do personal shopping for residents. Staff member B stated staff know they are not supposed to accept money from residents. Staff member B stated employees are educated on not accepting money from residents when they are hired. During an interview on 2/27/25 at 10:16 a.m., staff member U stated, I have brought in crafts for residents before. I did get in trouble for taking money from residents for supplies. It was a few months ago, and the administrator at the time told me I can't ask for or accept money from residents for crafts . During an interview on 2/27/25 at 12:40 p.m., staff member B said she assisted with the issue of staff accepting money for crafts and can write a statement now, but there was not anything from the time it happened. Staff member B stated, We just verbally spoke with the staff member. Review of staff member U's personnel record showed, on June 26, 2024, completion of Abuse, Neglect, and Exploitation training. Review of a facility document untitled and undated, showed, 4.14 Tips, Gifts, and Financial Transactions: Employees are not permitted to accept tips or gifts from anyone in connection to their employment or the facility. Employees are also not permitted to conduct personal financial transactions on behalf of or with patients. Employees may not borrow anything from a patient or loan any item to them. 2. During an interview on 2/24/25 at 2:55 p.m., resident #37 stated, I have had a lot of things go missing. Mostly small things like my marking pens. What bothers me the most is the amount of clothes that have gone missing. I've filed grievances, and clothes still go missing with the laundry; it's frustrating . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 2/24/25 at 3:21 p.m., resident #280 stated, I came to the facility with three bags of clothes, and now I'm down to just a couple pairs of pants. I haven't been here that long, and it's concerning . During an interview on 2/25/25 at 4:49 p.m., staff member B stated the facility doesn't have a specific policy for missing items; it is included in the grievance policy. During an observation and interview on 2/26/25 at 4:06 p.m., staff member P was observed assisting with activities. Staff member P stated, I have a bin for items that don't have a name on them. Everything is supposed to be labeled upon admission. Staff are encouraged to use a resident-specific laundry bag with their name on it. If staff let me know items are missing, I will look for them. If I had an inventory list for each resident, it would be easier to locate missing items. I was aware (resident #280) was missing some clothes, but I haven't had a chance to look for them. During an interview on 2/27/25 at 12:04 p.m., staff member F stated, If I am made aware of residents missing clothes, I will go upstairs and look for them. Or make a note of it and ask laundry. Review of a facility document titled, Standard Admissions Agreement with a revision date of 3/1/2019 showed: VII. Personal Property: . Loss of Personal Property: This facility is only responsible for loss or damage of personal property that is caused directly by facility management, employees, or agents. Lock boxes and/or secure storage areas are available. We encourage you to use these to store your valuables. This facility is not responsible for the theft, misplacement, loss or damage otherwise incurred to your personal property and this facility will not be responsible for the repayment or replacement of personal property . Review of a facility document titled, Filing Grievance/Complaints, with a revision date of 12/2021, showed: Policy Statement: Our facility will help residents, their representatives (sponsors), other interested family members, or resident advocates file grievances or complaints when such requests are made. Policy Interpretation and Implementation 1. Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning . theft of/missing property, etc., without fear of threat or reprisal in any form . 5. Upon receipt of a grievance and/or complaint, the resident advocate or designee will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and /or complaint . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. The grievance officer shall ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. [sic]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48261 Based on interview and record review, the facility failed to report an abuse allegation to the State Survey Agency within the required timeframe for 1 resident (#14); and failed to report their investigative findings to the State Survey Agency in a timely manner for 1 resident (#52), of 29 sampled residents. Findings include: 1. Review of a Facility Reported Incident, dated 12/12/24, reflected resident #14 was left on the toilet by a CNA who believed another CNA would be getting her off the toilet on 12/10/24. Resident #14 was found crying in her room stating a CNA left her on the toilet at 7:30 p.m. The alleged neglect initial report was not submitted to the State Survey Agency until 12/12/24 at 9:55 p.m. Review of the Facility Reported Incident final report, submitted 12/19/24, reflected a staff member was terminated due to the failure to report the incident to the facility abuse coordinator. 51111 2. Review of a Facility Reported Incident, dated 12/30/24, showed resident #52 was transported by staff from his room, to the hall's shower room, naked and not covered. Review of the facility reported incident findings, submitted 1/8/25, showed a former staff member was terminated due to interviews and review of video footage of her involvement in transporting resident #52 when naked and not covered in a common hallway, from his room, to the shower room. The facility provided a final written warning to the other staff member who was involved in assisting resident #52 into a wheelchair, who did not transport the resident. During an interview on 2/25/25 at 2:04 p.m., staff member B stated in January (2025), staff member A took over the role of administrator. Staff member B stated this was to replace the previous administrator, who was let go on January 14th (2025). Staff member B stated there was no facility reported incident documentation left by the previous administrator in any folders. Staff member B stated no other documentation for the facility reported incidents could be provided due to the previous administrator's departure, and stated The typical process is more accurate. The facility findings from investigation of the incident were due on 1/7/25. The facility investigation findings were not submitted to the State Survey Agency until 1/8/25. Review of a facility policy titled, Abuse Policy, revised 6/11/24, showed: Abuse Identification and Reporting: 1. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin and misappropriation of resident property are reported immediately, but no later than 2 hours, after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 51111 Based on interview and record review, the facility failed to ensure a complete investigation of a facility reported incident was completed, and failed to maintain and provide thorough investigation of the findings for 1 resident (#52) of 29 sampled residents. Findings include: Review of a Facility Reported Incident, dated 12/30/24, showed resident #52 was transported by staff from his room, to the hall's shower room, naked and not covered. The findings, submitted 1/8/25, showed one staff member was terminated for the event and the facility provided a final written warning to the other staff member involved. During an interview on 2/25/25 at 2:04 p.m., staff member B stated there was no facility reported incident documentation left by the previous administrator and stated the typical process is more accurate. An initial request was made to the facility for documentation of the facility's investigation notes for #52's reportable event on 12/30/24. The facility provided the following: - two written statements from staff members who learned of the incident from resident #52 while providing cares on 12/30/24, - one unlabeled document, not dated, which showed the name of the staff member involved in the incident who was given a final written warning with a one sentence quote. The information showed four sets of times with descriptions from video footage. The facility did not complete a thorough investigation as stated in the incident description, which showed investigation initiation notes of, interviews with other residents and staff members will be conducted to assess whether there are additional relevant details or patterns of behavior . A care plan review will be conducted to determine how to best support [resident #52] in this situation and address any further needs . Ongoing monitoring: Continued monitoring of [resident #52's] emotional and physical health will be prioritized, with ongoing updates provided as necessary. A second request was made to the facility for any documentation of investigation notes for staff and resident interviews about the facility reported incident of 12/30/24. The facility did not provide additional documentation by the end of the survey. Review of a facility policy titled, Abuse Policy, revised 6/11/24, showed: .Abuse Investigations 1. Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, shall conduct an investigation of the alleged incident. 2. The Administrator or designee shall interview any staff members, residents, family members or any others who may have knowledge of the incident and document a summary of interviews completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The Administrator or designee shall report the results of all investigations to the State Survey Agency within 5 working days of the incident .

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 52362 Based on interview and record review, the facility failed to provide written notice of the reason for a facility-initiated transfer to a resident or the resident's representative, for 3 (#s 29, 42, and 56) of 29 sampled residents, Findings include: 1. Review of resident #29's electronic medical record showed no documentation of a Notice of Transfer. A request was made by the survey team for the Notice of Transfer on 2/26/25, and no documentation was provided by the end of the survey. During an interview on 2/26/25 at 8:47 a.m., staff member F stated when a resident was transferred to the hospital, she would fill out a Notice of Transfer form, and send it with the resident. During an interview on 2/26/25 at 4:19 p.m., staff member B stated the facility ran out of transfer forms for a week during the time of resident #29's transfer. 48262 2. Review of resident #42's electronic medical record showed resident #42 was transported to the hospital for an acute change in condition on 11/1/24. The medical record failed to show the required written notice, with the reason for the transfer, was provided to the resident or representative. During an interview on 2/26/25 at 3:00 p.m., staff member D stated a Notice of Transfer/Discharge should have been completed by nursing staff, and provided to a resident or resident representative, prior to a resident leaving the facility. Staff member D stated the nurse would complete the form and it would then be scanned into the resident's electronic medical record. Staff member D stated she was not sure why the Transfer/Discharge notice had not been completed for resident #42 for his 11/1/24 hospital transfer. On 2/26/25, a request was made for a copy of resident #42's Notice of Transfer/Discharge, for the 11/1/24 facility-initiated transfer. No documentation or records were received from the facility by the end of the survey. 3. Review of resident #56's electronic medical record showed resident #56 was transported to the hospital for an acute change in condition on 9/24/24, 12/11/24, and 12/19/24. The medical record failed to show the required written notices of the reasons for the transfers were provided to the resident or resident's representative. During an interview on 2/26/25 at 4:19 p.m., staff member B stated a Notice of Transfer/Discharge was completed by nursing staff and provided to a resident or resident representative prior to a resident leaving the facility. Staff member B stated the facility had ran out of forms at one time, and it may have been why nursing staff did not complete the Notice of Transfer/Discharge for resident #56 on 9/24/24, 12/11/24, and 12/19/24. (continued on next page)

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	275120	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Billings Rehabilitation and Nursing LLC	600 S 27th St Billings, MT 59101

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	On 2/26/25, a request was made for a copy of resident #56's Notice of Transfer/Discharge forms for the 9/24/24, 12/11/24, and 12/19/24 facility-initiated transfers. No documentation or records were received by the end of the survey. Review of the facility's policy titled, Discharging/Transferring the Resident, with a revision date of December 2016, showed: . 1. once discharge or transfer is determined to be indicated or appropriate, the resident advocate or designee will provide the resident with a Notice of Discharge/Transfer that explains the reason for discharge .

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 52362 Based on interview and record review, facility staff failed to provide a Notice of Bed Hold to a resident or the resident's representative, for 2 (#s 29 and 56) of 29 sampled residents. Findings include: 1. During an interview on 2/26/25 at 4:19 p.m., staff member B stated a Notice of Bed Hold should be signed by someone, . either a POA, or they can take a verbal over the phone, and we can sign it. Review of resident #29's Bed Hold Notice, dated 12/22/24, reflected it was unsigned by resident #29 or resident #29's representative. 48262 2. Review of resident #56's electronic medical record failed to show the Notice of Bed Hold had been provided to the resident or the resident's representative, on 9/24/24 and 12/11/24, which was when the resident was transferred to a hospital. During an interview on 2/26/25 at 3:00 p.m., staff member D stated a Notice of Bed Hold was provided to a resident or resident representative prior to a resident leaving the facility. Staff member D stated the nurse would complete the form and it would then be scanned into the resident's electronic medical record. Staff member D stated, she was not sure why the Notice of Bed Hold had not been completed for resident #56 on 9/24/24 and 12/11/24, prior to the resident's transfers to the hospital. On 2/26/25 a request was made for a copy of resident #56's Notice of Bed Hold for the 9/24/24 and 12/11/24 transfer. No documentation or records were received from the facility for resident #56's Notice of Bed Hold, for dates 9/24/24 and 12/11/24, by the end of the survey. Review of the facility's policy titled, Bed Hold Policy, with a revision date of December 2006, showed: . 2. When emergency transfers are necessary, the facility designee will provide the resident or resident representative with information concerning the facility's bed hold policy within one business day of such transfer.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 52362 Based on observation, interview, and record review, the facility failed to accurately assess the dental needs of a resident on the comprehensive MDS assessment for 1 (#29) of 29 sampled residents. This deficient practice increased the risk to cause dental related complications due to lack of accurate assessment. Findings include: During an interview on 2/25/25 at 7:53 a.m., resident #29 stated he lost his dentures seven years ago, and was not offered help to get new dentures. During an observation on 2/25/25 at 12:23 p.m., resident #29 was observed being unable to chew a piece of broccoli and took it out of his mouth because he could not chew it. Resident #29 stated he has difficulty eating overcooked meat and undercooked vegetables without dentures. During an interview on 2/26/25 at 3:23 p.m., staff member M stated resident #29 was screened during admission for his dental needs, and most recently six weeks ago, which showed no dental issues, and stated, no indications or difficulties. Staff member M stated the MDS admission process was a team effort; nurses did a head-to-toe assessment, then she did the audit; dietitians, social services, and other services were involved too, depending on the resident's needs. Staff member M stated she was unaware resident #29 did not have dentures. Staff member M said there was not a formal process for MDS accuracy, but, There needs to be [a process] it sounds like. Review of resident #29's readmission screening assessment, dated 1/7/25, reflected resident #29 had upper and lower dentures and they fit. Review of resident #29's MDS, with an ARD of 1/13/25, reflected resident #29 did not have broken dentures, or difficulty with chewing. Review of the facility's policy titled, Resident Assessment Instrument, revised September 2010, showed: . 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48262 Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan, to include pertinent information to safely address resident care needs, within 48 hours of admission, for 2 (#75 and #282) of 29 sampled residents. Findings include: 1. Review of resident #75's electronic medical record showed resident #75 was admitted to the facility on [DATE]. Resident #75's baseline care plan showed a completion date of 12/14/24. During an interview on 2/26/25 at 3:00 p.m., staff member D reported nursing staff was responsible for completing the baseline care plan. Staff member D stated the care plans were updated as necessary during quarterly care plan meetings. During an interview on 2/26/25 at 4:06 p.m., staff member B reported nursing staff were responsible for initiating baseline care plans, and care plan updates were completed at IDT meetings and resident care conferences. Staff member B stated resident #75's baseline care plan was completed late, and she did not know why it was not completed within 48 hours of the resident's admission. 51111 2. During an observation on 2/25/25 at 8:23 a.m., resident #282 was sitting in a wheelchair beside his bed, with the back of the wheelchair facing the door. Resident #282 had plastic catheter tubing extending down from his side, that ended with a catheter bag. During an interview on 2/26/25 at 3:49 p.m., NF3 stated resident #282 had pulled on and messed with his urinary catheter many times since he entered the facility. NF3 stated she did not hear why he had so many catheter changes, but she knew he had at least three catheter changes. Review of resident #282's care plan showed an admitted [DATE], and pertinent medical diagnoses of, other acute kidney failure and other retention of urine. There was no documentation of a foley catheter, and the problems, goals, and interventions related to its use. Review of a nursing progress note for resident #282 dated 2/14/2025 at 7:13 a.m., showed: . was informed by CNA that resident had pulled his urinary catheter apart. went into room, resident's Foley was still in his penis but that he had pulled apart the tubing from the catheter therefore making it unusable. Resident could not explain how or why it was done. DC'd catheter with tip intact . [sic] Review of a nursing progress note for resident #282 dated 2/17/25 at 5:49 p.m., showed: Is fall risk, has FC and incontinent of bowel . Review of resident #282's February 2025 treatment administration record showed: (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Foley Catheter Care QS every shift for Prophylaxis -Order Date- 2/13/25 and Change urinary catheter one time a day every 1 month(s) starting on the 21st for 1 day(s) -Order Date- 2/20/25 [sic] Review of the facility document titled, Care Plans-Baseline, dated 12/2016, showed: Policy Statement A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48261 Based on observation, interview, and record review, the facility failed to implement a comprehensive care plan to include dialysis for 1 (#72); and, failed to include a resident's dental and respiratory needs on the comprehensive assessment, for 1 (#29) of 29 sampled residents. This deficient practice caused staff to not complete cares required post dialysis for resident #72 resulting in a risk for harm related to post-dialyzed complications, and increased the risk for resident #29 having respiratory issues and difficulty with eating. Findings include: During an observation on 2/24/25 at 3:01 p.m., staff member I stated resident #72 went to dialysis on Mondays, Wednesdays, and Fridays. During an observation and interview on 2/25/25 at 12:07 p.m., resident #72 stated staff do not take her vitals, assess her dialysis site, or check on her when she returned from dialysis. Resident #72 showed the surveyor her access site. Review of resident #72's EHR, dated 2/25/25, reflected no dialysis assessments had been completed since admission on 1/3/25. The baseline care plan, dated 1/4/25, reflected the patient was on dialysis. The comprehensive care plan did not reflect dialysis. The miscellaneous tab and assessment tabs in Point Click Care did not reflect any assessments were completed or scanned into the EHR. During an interview on 2/26/25 at 11:06 a.m., staff member C reviewed the EHR with the surveyor and stated she could not locate a care plan, any assessments after dialysis or a physician order. Staff member C stated resident #72 had been on dialysis since 11/11/24, according to the History and Physical. Review of the facility's policy titled, Hemodialysis Access Care, dated 12/19/16, reflected: - Coordination of Care with Dialysis Center Care 52362 During an observations on 2/24/25 at 3:28 p.m., and on 2/25/25 at 7:53 p.m., and 2/26/25 at 8:09 a.m., resident #29's oxygen tubing, connected to his CPAP, was dated 11/3/24. During an interview on 2/25/25 at 7:53 a.m., resident #29 stated he had been using a CPAP machine at night for a long time. Resident #29 stated no one checked his CPAP machine or the oxygen tubing, and it, . has never been changed before. Resident #29 stated he had not had dentures during his entire residency at the facility. During an observation and interview on 2/25/25 at 12:23 p.m., resident #29 took a piece of broccoli out of his mouth, because he could not chew it. Resident #29 stated he had difficulty eating overcooked meat and undercooked vegetables without dentures. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 10:16 a.m., staff member D stated if resident #29 needed dentures it would be on the most recent assessment or care plan, and she would ask, .how is your mouth, are there any appointments you would like us to make. Review of resident #29's Care Plan Report, dated 1/7/25, showed: - No interventions addressing the resident's need for dentures or difficulty chewing foods. - No interventions addressing the resident's need for oxygen tubing changes for his CPAP machine.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on interview and record review, the facility failed to thoroughly complete an elopement evaluation for a resident who was an elopement risk, and had attempted to elope. The resident was oriented to person only, upon admission, for 1 (#282) of 29 sampled residents. This deficient practice caused resident #282's responsible party to worry about his safety. Findings include: During an interview on 2/26/25 at 3:45 p.m., NF3 stated staff did not notify her of the use of a wander guard device for resident #282 following his attempt to leave the facility on 2/17/25. NF3 stated she had been to the facility to visit resident #282, and he stated, Look at this stupid thing on me. NF3 stated she asked resident #282 what happened, and why the device was on him. NF3 stated resident #282 replied to her that he tried to leave to go home. NF3 stated she is worried about him and does not feel staff were doing enough to supervise resident #282, based on his medical condition. NF3 stated she was concerned he was crying a lot when she went to visit him, and stated, How can he have already had two falls and tried to leave (the facility) in only two weeks he's been there? Review of resident #282's electronic medical record showed an admitted [DATE], and pertinent medical diagnoses including anoxic brain damage, not elsewhere classified, other acute kidney failure, and other retention of urine. There was no wander/elopement risk evaluation found in the EHR. Review of a nursing progress note for resident #282, from 2/14/25 at 10:27 a.m., showed: Oriented only to person . does not remember to not try to get out of w/c without assistance . Review of a nursing progress note for resident #282, from 2/17/25 at 5:49 p.m., showed: Late Entry . Resident is confused and tries to wander. Is fall risk, has FC and incontinent of bowel. Has peg feeds at night. Receives meds PO and receives assistant with eating during all meals. [sic] Review of resident #282's February 2025 treatment administration record showed: Order given for Wander guard- for safety awareness two times a day for safety -Order Date- 02/17/2025 [sic] Review of a facility policy titled, Elopements & Wandering, revised 4/16/21, showed: .Elopement: Leaving a supervised area to an unsupervised area without staff knowledge or the appropriate level of staff supervision . The wander/elopement risk evaluation shall be completed for all residents upon admission to the facility .

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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. 52362 Based on observation, interview, and record review, the facility failed to change oxygen tubing as ordered for 1 (#29) of 29 sampled residents. This deficient practice had the potential to increase the risk of respiratory infections. Findings include: During an observation on 2/24/25 at 3:28 p.m., on 2/25/25 at 7:53 a.m., and on 2/26/25 at 8:09 a.m., resident #29's oxygen tubing, connected to his CPAP, was dated 11/3/24 on a piece of tape wrapped around the tubing closest to the machine. During an interview during the 2/26/25 observation, resident #29 stated he had been using a CPAP machine at night for a long time, and he owned it. Resident #29 stated no one checked his CPAP machine or the oxygen tubing, and it, . has never been changed before. During an interview on 2/26/25 at 8:54 a.m., staff member F stated CNAs and Nurses were in charge of changing oxygen tubing, but mostly she did it. Staff member F stated oxygen tubing should be changed every 30 days. Staff member F stated she did not know the process for keeping track of oxygen tubing changes, and staff used to write the date on the cannula on a piece of tape with permanent marker, and stated, . maybe I can implement a system, I can usually tell if it's dirty or kinked. Staff member F, when seeing #29's oxygen tubing date, stated, Oh my God, that's terrible, I was told they changed that out after his hospitalization . During an interview on 2/26/25 at 9:30 a.m., staff member L stated the Nurses usually changed the oxygen tubing unless they told her to do it, or if she noticed the tubing was dirty, . Nurses have a schedule. Staff member L stated staff changed the oxygen tubing, but did not put tape with a date or document it anywhere. During an interview on 2/26/25 at 10:16 a.m., staff member D stated oxygen tubing should be changed every two weeks, on Sundays, during the night shift. Staff member D stated a CNA or anybody can change oxygen tubing. Nurses verify it was done, and charting should be done in the MAR/TAR, and, . hopefully initials, date and time is recorded, . my expectations are high. Review of resident #29's TAR, dated 1/7/25, showed, Change Oxygen Tubing every two weeks and PRN . every night shift every 14 days . A staff member signed off it was done on 2/11/25, and it was not done on 2/25/25. Review of resident #29's MDS, with an ARD of 1/13/25, Section O, reflected resident #29 was on intermittent oxygen therapy. Review of the facility's policy titled, Oxygen Administration, revised October 2010, showed, . 11. Oxygen tubing should be dated and labeled when new tubing is applied and changed weekly or in accordance with the Attending Physician order or manufacturer's instructions.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48261 Based on observation, interview, and record review, the facility failed to provide pre and post assessment care for a resident receiving dialysis for 1 (#72) of 3 sampled residents receiving dialysis. This deficient practice caused staff to not complete cares required post dialysis for resident #72 resulting in a potential for harm, including hypotension, renal failure, and infection at the access site. Findings include: During an observation on 2/24/25 at 3:01 p.m., resident #72 was not in her room. Staff member I stated resident #72 was at dialysis. Staff member I stated resident #72 went to dialysis on Mondays, Wednesdays, and Fridays. During an observation and interview on 2/25/25 at 12:07 p.m., resident #72 was in her room, in bed. Resident #72 stated staff do not take her vitals when she returned from dialysis, did not assess her access site, and the nurse did not come in to check on her when she returned from dialysis. Resident #72 showed the surveyor her access site. Review of resident #72's EHR, dated 2/25/25, reflected no dialysis assessments had been completed since admission on 1/3/25. The misc. and assessment tabs in Point Click Care did not reflect any assessments were completed or scanned into the EHR. During an interview on 2/26/25 at 11:06 a.m., staff member C reviewed the EHR with the surveyor and stated she could not locate a care plan, any assessments after dialysis or a physician order. Staff member C stated resident #72 had been on dialysis since 11/11/24, according to the History and Physical. Staff member C stated the risk of failure to assess dialysis patients before and after dialysis, especially bruits/thrills would be harmful. During an interview on 2/26/25 at 10:58 a.m., staff member B stated the dialysis procedures were to: 1. Complete vitals before dialysis, 2. Complete the dialysis form to the dialysis center, 3. Patient returns from Dialysis and the communication form should return with the resident 4. The nurse should complete the dialysis assessment, and the form is turned into the ADON for review and then is to be scanned into the EHR. Review of the facility's policy titled, Hemodialysis Access Care, dated 12/19/16, reflected: Documentation - The general medical nurse should document the resident's medical record every shift as follows: (continued on next page)

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	275120	A. Building B. Wing	02/27/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- . 7. Presence of bruit and thrill daily every shift as indicated based on the dialysis access device. Nurses shall notify the MD if there is no presence of bruit or thrill. - 8. If dialysis was done during shift, nurses shall complete the pre and post assessment sections on the dialysis communication form. - . 10. The licensed nurse shall monitor for, document and report to the attending physician any abnormal complications related to the dialysis access site, including signs and symptoms of infection, uncontrolled bleeding, signs of poor circulation in the applicable extremity, etc. - Coordination of Care with Dialysis Center Care - . 5. The facility licensed nurse is responsible to complete the pre and post sections of the dialysis communication form.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48262 Based on interview and record review, the facility failed to ensure scheduled subcutaneous medications were administered by staff licensed to administer the medications, for 1 (#3) of 29 sampled residents. Findings include: During an interview on 2/26/25 at 3:00 p.m., staff member D stated the facility had two full time certified medication aide II's who were utilized for medication administration to residents. Staff member D stated the medication aides are allowed to administer prefilled scheduled subcutaneous medications. Staff member D then referenced the Montana Code Annotated 2023 and stated, It appears the medication aide II is only allowed to administer prelabeled, pre-drawn insulin subcutaneously. Staff member D stated, Moving forward, all non-insulin subcutaneous injections will be administered by licensed nursing staff. During an interview on 2/26/25 at 4:08 p.m., staff member V stated she had administered resident #3's scheduled subcutaneous medications over the past six months. Staff member V stated because the medications were prefilled, and the injection was given subcutaneously she was allowed to administer the medications as a certified medication aide II. A review of resident #3's medication administration records from October 2024 through February 2025, showed Ozempic 0.25 mg subcutaneous injection administered by a certified medication aide II on the following dates: - October 21 and 28 of 2024, - November 4, 11, 18, and 25 of 2024, - December 2, 16, and 23 of 2024, - January 6, 13, 20, and 27 of 2025, and - February 3, 10, 17 and 24 of 2025. 17 total Ozempic 0.25 mg subcutaneous injections were administered by a certified medication aide II over a five-month period. A review of resident #3's medication administration records from September 2024 through February 2025, showed glatiramer acetate 1ml subcutaneous injection administered one time daily by a certified medication aide II as follows: -September 2024 21 days out of 30, -October 2024 17 days out of 31, -November 2024 24 days out of 30, (continued on next page)

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	275120	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Billings Rehabilitation and Nursing LLC	600 S 27th St Billings, MT 59101

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-December 2024 19 days out of 31, -January 2025 29 days out of 31, and -February 2025 25 days out of 26. 135 total glatiramer acetate 1ml subcutaneous injections were administered by a certified medication aide II over a six-month period. A review of the facility's document titled [Facility Name] Job Description: Certified Medication Tech/Aide, not dated, showed: . Summary of Accountabilities . Delivers routine daily oral, inhalation and topical medications to residents under direct supervision of a licensed nurse unless otherwise allowed by state law . [sic] A review of Montana Code Annotated 2023 TITLE 37. PROFESSIONS AND OCCUPATIONS CHAPTER 8. NURSING Part 4. Licensing Medication Aide II -- Scope of Practice showed: . Medication aide II -- scope of practice. (1) A licensed medication aide II may: (a) perform services requiring basic knowledge of medications and medication administration subject to the limitations outlined in subsection (2); . (2) A licensed medication aide II may not: (a) administer medications on an as-needed basis; (b) administer parenteral or subcutaneous medications except for prelabeled, predrawn insulin . [sic]

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 52362 Based on observation, interview, and record review, the facility failed to meet the resident's oral health needs for 1 (#29) of 29 sampled residents. This deficient practice had the potential to cause the resident to choke on their food. Findings include: During an interview on 2/25/25 at 7:53 a.m., resident #29 stated he had not had dentures during his entire residency at the facility, and staff had never asked him if he would like to get new ones. Resident #29 said it was sometimes hard to eat food. During an observation and interview on 2/25/25 at 12:23 p.m., resident #29 took a piece of broccoli out of his mouth, because he could not chew it. Resident #29 stated he had difficulty eating overcooked meat and undercooked vegetables without dentures. During an interview on 2/26/25 at 8:36 a.m., staff member F stated she was very familiar with resident #29. Staff member F stated resident #29 did not have dentures, and assumed he did not want them, I never thought to ask. Staff member F stated the ADON would set up the dental appointment if resident #29 wanted dentures. During an interview on 2/26/25 at 9:25 a.m., staff member L stated resident #29 did his own oral care and did not require her help, . he has no concerns with dentures or food. Staff member L stated if resident #29 wanted dentures he could get them, but resident #29 never asked about dentures. During an interview on 2/26/25 at 10:16 a.m., staff member D stated she was responsible for scheduling dental appointments. Staff member D stated residents, herself, other nurses, social workers, or doctors told her if a resident needed dental care. Staff member D stated dental care was discussed during admission and during readmission assessments. Staff member D stated resident #29 never brought up wanting dentures and stated, I let the VA guys bring up their own issues. Staff member D stated if resident #29 needed dentures it would be on the most recent assessment or care plan, and she would ask, .how is your mouth, are there any appointments you would like us to make. Review of resident #29's Care Plan Report, revised on 12/26/23, reflected: - ORAL CARE: The resident has (SPECIFY: own teeth, upper/lower dentures, broken teeth, carious teeth, sore gums, bridgework). The resident requires oral inspection every week and Report changes to the Nurse. [sic] - The resident has oral/dental health problems . Review of the facility policy titled, Dental Services, revised December 2016, showed, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessments and plan of care.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 52362 Based on observation, interview, and record review, the facility failed to provide food that accommodated a resident's intolerances and preferences for 1 (#29) of 29 sampled residents. This deficient practice caused resident #29 to feel frustrated at his preferences not being met. Findings include: During an observation on 2/24/25 at 3:28 p.m., an untouched food tray was on resident #29's bed while resident #29 was out of the facility for dialysis. During an observation and interview on 2/25/25 at 7:53 a.m., resident #29 picked up a banana off his breakfast tray and set it aside. Resident #29 appeared frustrated, and stated he was often given bananas with his breakfast even though he was on dialysis and did not want them. Resident #29 stated his breakfast was sometimes late on dialysis days, and he does not get to eat breakfast. Resident #29 stated, The lunches they used to give me were spoiled by the time I could eat them at dialysis. During an observation and interview on 2/26/25 at 8:20 a.m., resident #29 was wheeling down E hall with cranberry juice, and stated, They forget my juice and they know I like it with my coffee. Resident #29 appeared frustrated while wheeling himself back to his room using one arm and holding his juice with the other arm. During an interview on 2/26/25 at 9:40 a.m., staff member O stated she followed the meal ticket for resident #29's allergies, preferences, and dislikes. Staff member O stated resident #29 received what he preferred based on his diet, and sometimes the dietitian would make changes. Review of resident #29's Breakfast Diet Slip, dated 2/25/25 at 7:53 a.m., reflected: - Notes: ABSOLUTYLY NO BANANA. [sic] - Standing Orders: 4 fl oz Cranberry Juice. Review of resident #29's Care Plan Report, Focus on Dialysis, initiated on 7/29/21, reflected, I will receive appropriate diet lunch prior to leaving for dialysis.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service. This deficient practice had the potential to affect all residents receiving food from the kitchen. Findings include: During an observation and interview on [DATE] at 1:17 p.m., the following items were found in the kitchen storage: Open Worcestershire sauce: expired [DATE] Open Pancake/waffle mix- no date Open Chili Powder: expired [DATE] Open Parsley Flakes: no date Open Montreal Steak Seasoning: no date Open Pepperoni: no dates Blueberries: no date Opened Tortilla Shells: no date Opened Dry Yeast: no date Opened Mango preserves: no date Pineapple: use by date ,d+[DATE] Open Tuscan [NAME] Dressing: expired ,d+[DATE] Open Fat Free Italian dressing: expired ,d+[DATE] Open Thousand Island Dressing: expired ,d+[DATE] Open one-gallon balsamic Vinegar: no date Open bottle of molasses with brown crusty cap: no date Open Panco breading: no date Open bag of sugar: no date and sitting open to air (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Open Orange gelatin: no date Open bag of Orzo pasta: no date The following items were being stored on the floor in the hallway, next to the back exit doors, and in the closet, on the floor: - open case of coffee lids - cases of foam containers for serving - a case of portion cups - a case of dinner napkins - a case of foam hinged containers - a case of straws During an interview on [DATE] at 1:17 p.m., staff member K stated he was aware the cases of paper goods could not be stored on the floor and had planned to work on the issue as soon as shelving was ordered. Staff member K walked the kitchen store room with the surveyors and stated he was aware of the dating issues and was in the process of implementing a process using dating labels so staff could do a better job of dating products. Review of the facility's policy titled, Food Receiving and Storage, revised [DATE], reflected: - . 5. Food in designated dry storage areas shall be kept off the floor (at least 6 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents. - 6. Dry foods will be labeled and dated with appropriate use by date . 7. All food stored in the refrigerator or freezer will be covered, labeled and dated with an appropriate use by date . [sic]