| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275125 | A. Building<br>B. Wing | 02/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Living Centre | 57 Main St<br>Stevensville, MT 59870 |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update a comprehensive care plan with a resident's preferences for tobacco use for 1 (#35) of 21 sampled residents. Findings include:During an observation and interview on 2/23/26 at 12:51 p.m., resident #35 was in his bed and stated he was waiting for lunch. An over-the-bed table was in front of him, and it had a can of [NAME] (Tobacco) pouches sitting on it. During an interview on 2/24/26 at 1:18 p.m., staff member G stated he did not know of any resident in the facility who used tobacco products. Staff member G stated the facility was a tobacco-free facility, and he had never seen resident #35 with tobacco products.During an interview on 2/25/26 at 10:01 a.m., staff member F stated resident #35 uses [NAME] pouches and was not sure of their ingredients. Staff member F looked up resident #35's physicians' orders, which showed that resident #35 had an order for nicotine replacement pouches and not tobacco pouches.During an interview on 2/25/26 at 3:49 p.m., staff member B stated she was not sure whether resident #35 was using tobacco pouches or nicotine replacement pouches. Staff member B looked up the [NAME] pouches on the internet and verified that the pouches were a tobacco product containing nicotine. Staff member B stated the care plan, and his [resident #35] physician orders should reflect the tobacco product, and they did not. Staff member B stated resident #35 was on hospice for a short time, and hospice must have allowed him the tobacco pouches as he was using ZYN nicotine replacement pouches prior. Staff member B stated she would update the physician order and the care plan to reflect the [NAME] (tobacco) pouches instead of nicotine replacement products. Review of resident #35's comprehensive care plan with a revision date of 1/17/25, showed: Focus: I have used chewing tobacco for many years and often crave it.Goal: I want to stop chewing tobacco and remain comfortable without cravings associated with tobacco cessation during this assessment period.Interventions: I am aware that this is a tobacco-free environment. I have agreed to use nicotine pouches to curb my nicotine cravings. My physician has given an order to allow me to use nicotine replacement products, such as pouches, as needed when I am craving tobacco. Sometimes offering gum or hard candy will help me overcome my cravings for nicotine.Review of a facility document titled Care Plans, Comprehensive Person-Centered with a revision date of January 2026, showed: .1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interviews, and record review, the facility failed to obtain a physician's order for oxygen for 1 (#15); and failed to ensure the residents' oxygen tubing was clean and changed regularly for 2 (#s 14 and 15) of 21 sampled residents. Findings include:1. During an observation on 2/23/26 at 12:48 p.m., an oxygen concentrator was observed in resident #14's room with a tag on the tubing that had written initials and a date of 1/21/26. The oxygen tube had water built up inside it.During an interview on 2/23/26 at 1:13 p.m., resident #14 stated she did not know when the oxygen tubing was last changed on her oxygen concentrator.Review of resident #14's medication administration record for February 2026 showed: Physician order: Change oxygen tubing every 15 days, every night shift every 15 day(s) for oxygen with a start date of 11/21/25. This was marked as being done on 2/4/26 and 2/29/26. During an observation on 2/25/26 at 8:00 a.m., there was a tag on the oxygen tubing with the written initials and date of 2/24/26. This showed the oxygen tubing had been changed out on 2/24/26. There were 33 days in between the dates on the tags attached to the oxygen tubing.2. During an observation on 2/23/26 at 1:07 p.m., an oxygen concentrator was observed in resident #15's room. The tubing on the concentrator did not have any markings on it, and the nasal cannula was brown in color.During an observation on 2/23/26 at 1:49 p.m., resident #15 was in his bed sleeping. The resident's oxygen tubing cannula was placed in his nostrils, and the concentrator was on. During an observation on 2/24/26 at 12:48 p.m., resident #15's nasal cannula was brown in color. There was no label or date showing when the tubing/cannula was last changed. An oxygen sign was observed on the outside of resident #15's room. During an interview on 2/24/26 at 1:18 p.m., staff member G stated oxygen tubing should be changed daily, and the CNAs perform that task. During an observation and interview on 2/24/26 at 2:29 p.m., staff member J stated oxygen tubing should be changed every 30 days, and the night shift nurse performs that task. Staff member J stated that the staff who change the oxygen tubing should be marking the tubing with a piece of tape containing the staff's initials and the date the tubing was changed, as well as documenting it in the Treatment Administration Record (TAR). Staff member J stated if a resident was using oxygen, there should be a physician's order in their chart. Staff member J navigated to resident #15's chart in the computer and stated, Yeah, I think you are right, I do not see a physician's order for oxygen in resident #15's chart, and he has been using oxygen for quite some time.During an interview on 2/24/26 at 3:46 p.m., staff member B stated, When someone needs oxygen, we (the facility) have standing orders in place, and we would let the doctor know, and the doctor would sign an order for oxygen. Then the charge nurse would enter the order into the resident's medical record. Staff member B stated the oxygen tubing is changed every 15 days and the humidifier bottles are changed out every 30 days. Staff member B stated this would be documented in the Treatment Administration Record as well as on the tubing itself. During an interview on 2/24/26 at 4:38 p.m., staff member B stated resident #15 had been on oxygen since April 2025. Staff member B stated a physician's order should have been entered into resident #15's chart at that time. Staff member B stated the previous case manager started the physician's oxygen order in resident #15's chart after he had been discharged from hospice and never finished entering it into the record. Staff member B stated there should have been a physician's order in resident #15's chart for oxygen therapy. During an interview on 2/25/26 at 11:25 a.m., staff member B stated she asked staff when the last time resident #15's oxygen tubing was changed, and they thought it was changed on 1/31/26. Staff member B stated she could not verify when the oxygen tubing was changed since there was no physician's order in resident #15's chart to change the oxygen tubing.Review of resident #15's medication administration record for February 2026 failed to show a physician's order for oxygen therapy or a physician's order to change the oxygen tubing. Review of a facility document titled Oxygen Administration, with a revision date of December 2025, showed: Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration.Preparation: 1. Verify that there is a physician's order for this procedure. Review the<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | physician's orders or facility protocol for oxygen administration.Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record:1. The date and time that the procedure was performed.3. The rate of oxygen flow, route, and rationale.4. The frequency and duration of the treatment. |