STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275126	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation	1301 E Broadway Missoula, MT 59802

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48268 Based on interview and record review, the facility failed to update a care plan to reflect a new pressure wound, for 1 (#7) of 11 residents sampled for wounds. The failure placed the resident at risk for improper wound care, wound progression, and infection. Findings include: During an interview on 3/24/25 at 2:05 p.m., resident #7 stated she has had wounds in the past and had a buttock wound currently related to paraplegia. During an interview on 3/25/25 at 9:45 a.m., staff member A stated the care plan should reflect all current care concerns for each resident. Staff member A stated the care plans are updated by the wound care nurse for any new wounds, including any new interventions or treatments. Review of resident #7's nursing progress notes showed a new pressure wound identified on 3/4/25, which remained unhealed as of the end of the survey period. Review of resident #7's care plan, initiated on 2/5/25 with revision on 2/17/25, failed to show the pressure wound identified on 3/4/25. The care plan noted an alteration in skin integrity from a sacral wound present on admission that was resolved. No updates were made to the care plan to reflect the resolution of the initial wound first noted on 2/5/25, and no updates were made to reflect the current management of the current pressure wound identified on 3/4/25.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48268 Based on observation, interview, and record review, the facility failed to implement wound prevention measures for a resident with history of pressure wounds and elevated risk for the development of pressure ulcers; failed to implement pressure relieving measures after the development of a new Stage II sacral wound, and failed to accurately assess and monitor a new Stage II sacral wound for 1 (#7) of 11 residents sampled for wounds. The wound management failures placed the resident at risk for wound progression and infection. Findings include: During an observation and interview on 3/24/25 at 2:05 p.m., resident #7 was seated in a wheelchair in her room. There was no pressure relieving air mattress or overlay on resident #7's bed. Resident #7 stated she had a wound on her buttock and has had several wounds in the past related to paraplegia. Resident #7 stated, I heard through the grapevine that I would be getting an air mattress, but I haven't seen one yet. During an interview on 3/25/25 at 8:35 a.m., staff member B stated resident #7 had a pressure wound on her left buttock which was new as of the date of the interview and had notified the nurse on duty. During an interview on 3/25/25 at 8:44 a.m., staff member C stated she was not aware of a new pressure wound on resident #7. Staff member E stated, She (resident #7) has had some maceration and irritation on the left buttock and gluteal fold for a few weeks and we have been putting some barrier cream on it. During an interview on 3/25/25 at 9:45 a.m., staff member A stated the facility's process for addressing new wounds would be a secure message from the nurse to the DON, wound care nurse, and all licensed nursing staff. The wound care nurse came every Wednesday and would implement treatment. Interim treatment, if required, would be implemented by the DON. The DON would then add the secure message to the progress notes in the EHR. During the interview, staff member A stated she realized the facility had failed to follow up appropriately on resident #7's buttock wound, and stated she would have an air mattress placed on resident #7's bed today. Review of resident #7's nursing progress notes, dated 3/4/25, showed a secure message sent from staff member D to all licensed nursing staff, as well as the DON and wound care nurse as follows: Subject: New Wound . Resident has a 1.5 cm open area on her sacrum, site cleansed with NSS and covered with optifoam, and shearing noted to left buttock, resident also continues to have redness in groin with no improvement with ordered creams. Review of resident #7's nursing progress notes, dated 3/5/25 at 2:49 p.m., showed the wound care nurse replied to the secure message as follows: Resident with linear excoriation to upper sacral area, and bilateral gluteal creases. Recommend prevent barrier cream BID and PRN after incontinence episode. Would encourage air overlay or air mattress as well. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #7's nursing progress notes, dated 3/13/25 at 2:49 p.m., showed IDT met to discuss skin concerns. [Resident] has MASD on her buttocks. New 1.5 cm open area on her sacrum, site cleansed with NSS and covered with optifoam, and shearing noted to left buttock, resident also continues to have redness in groin with no improvement with ordered creams. Catheter in place. Applying barrier cream. Resident encouraged to get OOB and participate in activities. Air mattress will be placed to prevent further breakdown. IDT will continue to monitor. Review of resident #7's nursing progress notes, dated 3/19/25 at 1:01 a.m., showed, ALERT NOTE: New skin issue noted -please address. With current order for barrier cream to prevent further skin breakdown. Off loaded hip alternately with pillows. [sic] No additional wound or skin assessment documentation was located in the EHR for resident #7's wound for the period of 3/4/25 through 3/24/25. Review of facility policy, titled, Pressure Ulcer/Pressure Injury Prevention and Management, dated 10/14/24, showed: 1. Assessment of Pressure Ulcer/Pressure injury Risk . c. Conducted a full body skin assessment . after any newly identified pressure ulcer/pressure injury . e. Provide interventions based on specific factors identified in the risk assessment and skin assessment (e.g. , moisture management, impaired mobility, nutritional deficit, etc . 2. Interventions for Prevention and to Promote Healing . - a. Implement interventions for prevention for all residents who are assessed at risk or who have a pressure ulcer/pressure injury present - b. Document interventions in the care plan - c. Document compliance with interventions in the weekly summary charting - d. Modify interventions as needed . Review of the facility policy titled, Documentation of Wound Treatments, dated 10/14/24, showed: Treatment Documentation Guidelines: . 1. Type of wound . 2. Ulcer stage/injury stage, if pressure ulcer (I, II, III, IV, unstageable, deep tissue injury)/pressure injury or wound depth, if non-pressure (partial or full thickness) . 3. Measurements done weekly and prn: height, width, depth, undermining, tunneling . 4. Description of wound characteristics . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a. Color of the wound bed -b. Type of tissue in the wound bed (i.e. granulation) -c. Temperature of the peri-wound (warm, inflamed, macerated) -d. Drainage/Exudate -e. Odor -f. Pain . 6. Weekly progress towards healing, effectiveness of current interventions .