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	01/15/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to provide pain management which was acceptable to the resident's goals for 1 (#3) of 25 residents sampled. The deficient practice resulted in poor pain management and decreased quality of life for the resident who consistently reported having severe pain. Findings include:During an observation and interview on 1/14/26 at 3:45 p.m., resident #3 stated the pain in his back was horrific and rated it as 8/10. Resident #3 stated he pretty much always had back pain, and he did not feel the facility controlled it well. Resident #3 stated he would consider 5/10 to be an acceptable pain level. Resident #3 stated he had taken pain medication at noon and wanted something more for the pain. Resident #3 was observed lying in bed, grimacing, wincing, and frequently shifting his weight in the bed, during the interview.During an interview on 1/14/26 at 3:53 p.m., staff member M was notified of resident #3's pain and stated resident #3 had chronic pain issues. Staff member M stated nursing staff was responsible for notifying the resident's provider if pain was not well managed and did not know if the provider had considered any changes to resident #3's pain management to better assist with pain control. During an interview on 1/14/26 at 5:23 p.m., resident #3 reported he was still experiencing pain and rated it as 8/10. Resident #3 stated he had not received further pain medication since previous interview at 3:45 p.m., and the dose before this was given around noon that day per the resident. During an interview on 1/14/26 at 5:25 p.m., staff member N stated she attempted to contact the resident's provider, but the provider had not responded back. Staff member N stated she felt resident #3's pain control had been adequate. Staff member N stated it had not been well controlled that day (1/14/26), and resident #3 looked like he was hurting. Staff member N reported participation in therapy made resident #3's pain worse. Staff member N stated that nursing was not able to pre-medicate resident #3 for pain prior to therapy sessions because there was not set times for his therapy sessions. Staff member N stated she was unaware of the provider having been contacted about resident #3's pain management prior to 1/14/26.A review of resident #3's Care Plan showed,Goal: [Resident Name] will have pain managed AEB decreased non-verbal S/SX of pain and resident reporting acceptable level of pain in the next 90 days. [sic] The target date listed was 1/1/26.Interventions: . Notify MD of adverse effects or if pain medication ineffective PRN. Observe effectiveness of pain interventions and need for additional measures. Resident reports acceptable level of pain = 4. [sic]A review of resident #3's MAR for 1/14/26, showed:-acetaminophen 500 mg was administered at 6:00 a.m. and 2:00 p.m.-Lidocaine External patch 5% was applied at 8:00 a.m.-Gabapentin 300 mg was administered in the morning. -Hydrocodone/acetaminophen 7.5-325 mg was administered at 12:30 p.m. for a pain rating of 8/10. It was marked ineffective.-The MAR showed a pain rating of 7 to 10 was classified as severe.A review of resident #3's TAR for 1/14/26, showed:-pain monitoring on the 7:00 a.m. to 7:00 p.m. shift with pain rated as 8/10.-Interventions documented on the TAR included: 1. Repositioning, 2. Dim light/quiet environment, 5. Relaxation technique, and 6. Distraction. The entry was marked not effective.A review of resident #3's Pain Level Summary showed, between 1/6/26 and 1/14/26, resident #3's pain was documented at 7 or above (severe) 23 out of 49 times and occurred at a level of 7 or above (severe) daily.A review of a facility policy titled, Pain Management Program, last reviewed on 10/27/25, showed: Treatment:1. If (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 0697 Level of Harm - Actual harm Residents Affected - Few	the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified. Monitoring:. 2. If re-assessment findings indicate pain is not adequately controlled, revise the pain management regimen and plan of care as indicated. [sic]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interviews and record review, the facility failed to serve the substituted menu items to meet the nutritional needs of residents in accordance with established national guidelines and have the facility's dietitian review the changes for nutritional adequacy for 2 (#s 40 and 69) of 25 sampled residents. This deficient practice resulted in the residents becoming frustrated with menu selection and residents receiving food from the kitchen were not having nutritional needs met. Findings include: 1. During an interview on 1/13/26 at 4:11 p.m., resident #40 stated he wanted the chef salad alternate for lunch, but the kitchen sent everyone who ordered the chef salad chicken tenders instead. Resident #40 stated the kitchen often messed up the menus, and she was frustrated by the confusion. Resident #40 stated the CNAs .came around the night before and got your mouth watering for one thing, only to be disappointed the next day, when you did not get what you ordered. 2. During an interview on 1/13/26 at 4:20 p.m., resident #69 stated she would have preferred to receive the salad but had been served chicken tenders instead. During an interview on 1/13/26 at 12:40 p.m., staff member L stated that the night CNAs used the wrong menu day, and some residents were told they would receive chicken tenders. Staff member L stated that the kitchen decided to serve chicken tenders instead of the chef salad. Staff member L stated the plan was to serve chicken tenders for the dinner alternative as well. During an interview on 1/13/26 at 12:45 p.m., staff member D stated he did not get approval from the dietician to change the menu and stated he did not give authorization for the kitchen to change the menu. Review of the menu for week two, day 3, showed the alternate was the chopped chef salad for both lunch and dinner. During an interview on 1/13/26 at 1:20 p.m., staff member G stated she had not given approval for any menu changes and would want to verify that what was being served with the chicken tenders would still meet the nutritional requirements of the meal before approving the replacement. During an interview on 1/14/26 at 9:10 a.m., staff member D stated the CNAs used the incorrect menu list, again, last night (1/13/26), but the staff went around and asked the residents for menu selections again to correct the tickets. During an interview on 1/14/26 at 9:34 a.m., resident #40 stated she received the chef salad last night, but it did not have any meat on it. Resident #40 stated it was basically a side salad. During an interview on 1/14/26 at 9:40 a.m., resident #69 stated the chef salad did not have meat on it. During an interview on 1/14/26 at 4:41 p.m., staff member H stated the chef salad served for dinner on 1/13/26 did not have meat on it. During an interview on 1/14/26 at 4:47 p.m., staff member I stated the chef salad served on 1/13/26 for dinner did not have meat, and it was not served with any additional items. During an interview on 1/14/26 at 5:00 p.m., staff member D stated the chef salad should have been served with two ounces of turkey and two ounces of ham. During an interview on 1/15/26 at 11:33 a.m., staff member G stated that if the meat was not included on the chef salad, the chef salad would not meet the protein requirement for residents and the meal. Review of the facility's Dining Manager Chopped Chef's Salad, not dated, reflected that the chef salad recipe was a two-cup portion, which included 3/4 ounces of turkey and 3/4 ounces of ham. Review of the facility's policy, Food Preparation, dated 9/26/22, reflected: - . 1. The cook, or designee, shall prepare menu items following the facility's written menus and standardized recipes.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record reviews, the facility failed to ensure food was served that was palatable, attractive, and at a safe and appetizing temperature for 7 (#s 40, 41, 49, 56, 66, 69, and 79) of 25 sampled residents. This deficient practice resulted in the residents' dissatisfaction with the food, and it potentially affected any resident who received food from the kitchen. Findings include: During an interview on 1/12/26 at 12:11 p.m., staff member R stated that when the food trays are delivered to the hall, the floor staff deliver them immediately. Staff member R stated that if the resident was not ready to eat, the tray was left on the bedside table in the room until the resident was ready to eat. Staff member R stated she did not check food temperatures before the residents started eating, and she did not reheat the food before the resident ate. Staff member R was not able to state what the temperatures the food should be served at, and she was unaware of anyone checking the temperatures of the meals/food once it was delivered to the halls to be passed out. During an interview on 1/12/26 at 1:40 p.m., resident #66 stated the food did not taste good. Resident #66 stated, The food has a funny taste, and stated, The soup we had a couple of days ago tasted rancid. Resident #66 stated he had been in the facility for a month, and the taste of the food had been an issue for the duration of his stay. During an interview on 1/12/26 at 2:03 p.m., resident #69 stated the meat was dry, hard to chew, and usually cold. Resident #69 stated she often could not eat the meat served. During an interview on 1/12/26 at 2:12 p.m., resident #41 stated the food was not good. Resident #41 stated she was tired of chicken being served over and over, and just adding sauce to the chicken did not make it better. Resident #41 stated the food was consistently cold and the meat was rubbery. Resident #41 stated she had complained several times, but staff member C did not listen to the resident concerns. During an interview on 1/12/26 at 2:17 p.m., resident #40 stated the facility served chicken and rice too often, and the food was cold. Resident #40 stated the chicken looked like chunks glued together with something, and it was like eating tasteless rubber. Resident #40 stated the food was so bad that she often depended on junk food to substitute her meals, or she would just go hungry. During an interview on 1/12/26 at 2:27 p.m., resident #56 stated the food was awful. Resident #56 stated the food was cold and agreed with the roommate that the chicken was like rubber chunks stuck together. During an interview on 1/12/26 at 3:48 p.m., resident #49 stated the food provided by the facility did not taste good and the flavor of the food needed improvement. Resident #49 stated he wanted more variety and selection, especially when the facility served items he did not like. Resident #49 stated the food arrived cold most days. During an observation and interview with staff member F, on 1/13/26 at 8:19 a.m., trays were sitting in the kitchen window. The food temperatures taken were as follows: - Biscuits and gravy: 100 degrees (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Eggs: 110 degrees Staff member F stated the trays were for residents who had not arrived at the dining room. Staff member F stated that some residents came in late because they wanted to sleep in. Staff member F stated the temperature was not usually checked after the tray was made. Staff member F stated that the kitchen staff complete temperature checks on the tray line when serving the meals, but not after the tray was made. Staff member F stated she did not know when the two residents would arrive for breakfast so that they could receive the trays in the window. The kitchen was beginning to take down the service line in preparation for making lunch. During an observation on 1/13/26 at 8:25 a.m., temperatures were taken for the meal trays taken to the halls, which were to be delivered to residents in their rooms, and the five trays checked were as follows: - Biscuits and gravy: 107 degrees - Biscuits and gravy: 99 degrees - Ground meat: 100 degrees - Eggs:130 degrees During an interview on 1/13/26 at 11:05 a.m. resident #79 stated, It's not the best food in the world, and reported the food was bland and the eggs tasted funny. Resident #79 stated the food was edible, but not what she wanted to eat. Resident #79 stated she wanted more options for the meals. Review of a facility policy, Food Temperatures, dated 7/25/18, reflected: - . 1b. Hot food items may not fall below 135 degrees F (Fahrenheit) after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees F and reheated to at least 165 degrees F prior to serving. - 6. Foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to the unit storage area to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods. Review of the facility policy, Food Preparation, dated 9/26/22, reflected: - . 3. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature.

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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** Based on observations, interviews, and record reviews, the facility failed to date and monitor refrigerated foods, dry goods, and items brought in by families, to ensure items were used by the use-by date or discarded, and the facility failed to store food items off the floor. This deficient practice placed residents who received meals from the facility at risk of food-borne illness. Findings include:During an observation and interview on 1/12/26 at 10:10 a.m., the following items were found in the kitchen: - [NAME] sauce with no open or discard dates, brought in by family,- Goddess dressing with no open or discard date, brought in by family,- Soy Sauce with no open or discard date,- Dijon Mustard with no open or discard date, and a manufacturer's expiration of 4/5/25,- Raw honey with no open or discard date,- Vanilla flavoring with no open or discard date,- Olive Oil Mayonnaise with no open or discard date, - Teriyaki sauce with no open or discard date,- Enchilada sauce with no open or discard date,- Heavy-duty Mayonnaise with no open or discard date, and no manufacturer's expiration date on the bottle,- [NAME] dressing with no open or discard date,- Honey mustard with no open or discard date,- BBQ sauce with no open or discard date,- sliced cheese box with no open or discard date,- One half of a brick of cream cheese with no open or discard date,- Bucket of strawberries in juice with no open or discard date,- Frozen pancakes in a Ziplock bag, labeled with a resident's name, with no date, brought in by family,- Frozen waffles in two Ziplock bags, labeled with a resident's name, with no dates, brought in by family; and- Frozen donuts in two Ziplock bags, labeled with a resident's name, with no dates, brought in by family. During an interview on 1/12/26 at 10:12 a.m., staff member D stated all open food items were only good for seven days, and anything without an open date should be thrown out. During an interview on 1/12/26 at 10:14 a.m., staff member F stated, Good question, when asked how the kitchen would know when open items expired. Staff member F stated there was no list to follow that showed when to throw out food items in the kitchen. During an observation on 1/14/26 at 9:15 a.m., the following items were found in the kitchen: - Ground Ginger expired on 3/22/25,- Ground Coriander expired on 3/21/25,- Ground Allspice expired 7/22/23,- Fancy Pickling Spice expired 7/24/24,- Three open jars of Ground Marjoram expired 11/6/22,- Rubbed sage expired 10/26/23,- Ground Mustard expired 7/21/25,- Caraway seed expired 9/22/25, and - Pork Spice rub expired 7/10/25. During an observation on 1/15/25 at 9:04 a.m., the following items were found in the walk-in refrigerator stored on the floor: - Three milk carton cases- One five-gallon bucket of pickles Review of the facility's policy, Date Marking for Food Safety, dated 8/14/18, reflected: ' . 3. Condiments in their original containers can be used until manufacturer's use by date. 4. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. (use by date) 5. The individual (staff member) opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. Review of the facility's policy, Foods Brought in by Family Visitors, dated 11/27/17, reflected: . 2. All food items that are not in original containers brought in by the family or visitor must be labeled with use by date.b. Food not in its original container must be consumed by the resident within 4 days.

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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. Based on observations and interviews, the facility failed to maintain a comfortable environment for residents by maintaining a temperature range of 71 to 81 F in resident rooms for 1 (#64) of 25 sampled residents. This deficient practice resulted in resident #64 being cold. Findings include: During an observation and interview on 1/12/26 at 4:02 p.m., resident #64 was in her room with the door closed. Resident #64 was in bed covered with several blankets and stated she was cold. The thermostat was set to 75 degrees and the current temperature reading was 65 degrees.During an observation and interview on 1/12/26 at 4:10 p.m., staff member C used a temperature gun and tested the room temperatures at the request of the surveyor. The following temperatures were noted:- Room D102: 64 degrees- Room A112: 66 degrees- Room D104: 66.5 degrees- Room D108: 67 degrees- Room A101: 63 degrees- Room A103: 67 degreesStaff member C stated [Repair company name] had been in the building in the morning to drain a heat system line and had the heat turned off for those repairs. Staff member C stated the repairs only affected half of D hall. Staff member C stated he had not checked temperatures after the repairs were completed and was not notified by the floor staff of the cold temperatures on the unit. Staff member C stated he was calling the repair company back for an emergency repair.During an interview on 1/12/26 at 5:00 p.m., staff member A stated the facility offered residents extra blankets and room doors would remain open to allow heat in the hallway to warm the rooms. Staff member A stated the repair company was in route to the facility to determine what was wrong with the heat. Staff member A stated the floor staff should have notified the maintenance department and her of any temperature extremes immediately. Staff member A stated the facility would be offering hot drinks and soup to residents as well.During an interview on 1/12/26 at 7:41 p.m., staff member K stated his findings included bleeding the water lines for the heat, a computer component in the air handler was not working and found four thermostats in the rooms were not working. Staff member K stated each thermostat controlled two to three rooms. Staff member K stated he diverted the heat to ensure even heat for the night and would replace the thermostats in the morning, when parts were available.During an interview on 1/13/26 at 3:10 p.m., staff member C stated the heating repairs had been completed and room temperatures had risen to 71 degrees or higher. During an observation and interview on 1/13/26 at 4:15 p.m., staff member C used the thermostat gun to check the temperature in resident rooms. Findings included:- Room D102: 68 degrees- Room D104: 69 degreesThe thermostat on the wall showed 75 degrees and was set to 80 degrees. Staff member C stated he would be calling the repair company back for an emergency call. Resident #64 was in bed sleeping with several blankets layered on top of her.During an interview on 1/14/26 at 1:09 p.m., staff member C stated the thermostat in room D102, that controlled D102 and D104 was faulty and had been replaced in the morning. Staff member C stated the temperature was holding at 74 degrees and he would continue to check temperatures for all rooms twice daily over the next few weeks to ensure there were no further temperature issues.During an observation and interview on 1/14/26 at 1:20 p.m., resident #64 was in bed resting, with the blankets off. Resident #64 stated she was comfortable and no longer cold.

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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. Based on observation, interview and record review, the facility failed to provide clean equipment for respiratory treatment for 1 (#69) of 5 residents sampled. This deficient practice placed the resident at risk for inhalation of foreign material and respiratory infections. Findings include:During an observation on 1/12/26 at 2:03 p.m., resident #69's nebulizer was observed to have a white crust and buildup on the mouthpiece and corrugated aerosol tubing that extended from the mouthpiece.During an interview on 1/14/26 at 12:16 p.m., staff member B stated that nursing staff were responsible for changing the nebulizer equipment and that this was done weekly. Staff member B stated that an order for changing nebulizer tubing was entered into the chart so it would alert the nursing staff to change the tubing each week.During an interview on 1/14/26 at 12:40 p.m., staff member P stated she did not know when resident #69's nebulizer tubing or mouthpiece had been changed. Staff member P stated the respiratory therapist was responsible for changing them weekly and was not sure why resident #69's nebulizer had not been changed.During an observation and interview on 1/14/26 at 2:00 p.m., resident #69's nebulizer was observed to still have a white crust and buildup on the mouthpiece and corrugated aerosol tubing that extended from the mouthpiece. There was no date on the nebulizer tubing or mouthpiece to show when it was last replaced. Resident #69 was unable to state when it had last been replaced. Resident #69 stated she had used her nebulizer since it was last replaced.A review of resident #69's physician Order Summary Report, dated 1/14/26, showed there was no physician order for changing the nebulizer tubing.Review of a facility policy titled, Nebulizer Treatments, last reviewed 10/27/25, showed: . Procedure:. 3. Nebulizer tubing to be changed weekly or according to facility protocol. [sic]