STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275127	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweet Memorial Nursing Home	125 Airport Rd Chinook, MT 59523

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to routinely monitor and document a resident's weight in the resident's record, failed to ensure comprehensive quarterly nutritional assessments were completed timely to analyze and evaluate related factors for a severe weight loss, and failed to revise a residents care plan to prevent an avoidable weight loss for 2 (#s 15 and 20) of 20 residents sampled. Resident #15 had a severe 9.75% weight loss in the last three months, and 17% in the last six months. Resident #20 had a severe 6% weight loss in 29 days, and a severe 8% weight loss of her body weight in 92 days. This deficient practice had the potential to affect all residents at risk for nutritional deficit. Findings include:1. During an observation on 1/27/26 at 8:44 a.m., resident #15 was sleeping in bed during breakfast. During an observation on 1/27/26 at 9:23 a.m., resident #15 was sitting on a dining chair along the wall by the nurses' station. Her dentures were notably oversized in her mouth when trying to speak. During an interview on 1/28/26 at 11:53 a.m., staff member B stated that the facility management had recently begun monitoring weight loss in the weekly care plan meetings. Staff member B stated resident #15 was not noted to have a current weight loss, so she was not on the IDT lists for monitoring and interventions. During an interview on 1/28/26 at 3:27 p.m., staff member B brought in documents for resident #15 explaining in late 2024 she was placed on small portions by the provider due to weight gain up to 214 pounds, believed to have been from a psychotropic medication she had been on. Staff member B explained they asked to put her back on regular portions, but the provider denied to order it and ordered a supplement if the resident refused to eat a meal. During an interview on 1/28/26 at 3:52 p.m., staff member L stated the facility had two dieticians who rotated coming onsite monthly. Staff member L stated she would prepare a list of residents due for each dietician to review for regular assessments, weight changes, or difficulties eating. Staff member L stated that for any changes, the dieticians would give her a written recommendation to give to the provider to review and order what they determined was needed. The dieticians had access to the EHR offsite. Staff member L stated resident #15's family wanted her to lose weight after she had gained a lot of weight and would not get out of bed all day, so the provider placed her on small portions. During an interview on 1/29/26 at 11:16 a.m., staff member H stated that staff member L would provide her with a resident list for her visits, which were rotated monthly with another dietician. Staff member H stated they followed the care plan calendar for nutritional assessments, and if she had a recommendation, it would be written and given to the provider to write an order if they agreed. Staff member H stated that due to the limited onsite visits, she did not see the residents to do the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0692 Level of Harm - Actual harm Residents Affected - Few	evaluations and did not meet with the provider or participate in the facility IDT meetings. Staff member H stated neither dietician did care planning for the residents' nutritional needs. Staff member H stated that she been at the facility earlier in the month but could not recall resident #15 or any concerns with the resident. Review of resident #15's EHR weights, in pounds, for August 2025 to January 2026, showed a 17% weight loss in the last six months, with a 9.75% weight loss in the last three months. The weights in the medical record showed: - 8/4/25, 174.0 - 8/11/25, 173.0 - 8/18/25, 169.0 - 8/25/25, 170.0 - 9/1/25, 168.5 - 9/15/25, 168.5 - 10/6/25, 162.5 - 10/13/25, 159.5 - 10/27/25, 161.5 - 11/3/25, 159.5 - 11/24/25, 154.5 - 12/1/25, 156.0 - 12/15/25, 153.0 - 12/22/25, 154.0 - 12/29/25, 150.0 - 1/12/26, 150.5 - 1/19/26, 143.5 Review of resident #15's diet orders showed she had a regular diet with small portions. A supplement was to be offered if she did not eat a meal. Review of resident #15's Mini Nutritional Assessment, completed on 11/24/25, showed she was at risk of malnutrition. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of resident #15's dietician written recommendation on 11/18/25 showed, 4 oz. supplement of choice TID at meals D/T significant weight loss of 14lbs over past quarter. Review of resident #15's Care Plan, last updated 6/5/25, showed a focus area for unplanned/unexpected weight loss due to sleeping and refusing to get out of bed, and there was a goal of maintaining a weight of 169 pounds through the 6/2/26 review. 2. During an observation on 1/27/26 at 2:00 p.m., resident #20 came out of her room and sat in a chair by her bedroom. The resident's face and arms appeared thin and gaunt and were prominent through her skin. During an observation and interview on 1/28/26 at 10:51 a.m., resident #20 was walking down the hallway with staff member Q. The resident stated she had not had breakfast. The resident was offered a sandwich and a cola, but was not offered a nutritional supplement. Review of resident #20's weights from 9/10/25 to 1/28/26 showed the resident weighed 108 pounds on 9/10/25 and 99 pounds on 12/10/25. The resident had an 8% weight loss of her body weight in 92 days. On 12/3/25, the resident weighed 106 pounds, and on 12/31/25, the resident weighed 99 pounds. The resident lost 6% of her body weight in 29 days. Both were severe weight losses. a. Monitoring Review of resident #20's weights from 9/10/25 to 1/29/26, showed: - 9/10/25: 108.7 lbs. - 10/1/25: 102.5 lbs. - 10/8/25: 109.5 lbs. - 10/15/25: 107.0 lbs. - 11/19/25: 108.5 lbs. - 12/3/25: 106 lbs. - 12/10/25: 99 lbs. - 12/18/25: 103.5 lbs. - 12/31/25: 99.5 lbs. Weights were not obtained or documented weekly in September and November 2025, and there were no documented weights from 12/31/25 to 1/28/26. Review of resident #20's Dietitian Weight Graph document showed one weight recorded for September, which was on 9/10/25 for 108.7 pounds. No additional comments were noted about the missing weekly weights in September. For October, three weights were recorded on 10/1/25 for 102 pounds, 10/8/25 for 109 pounds, and 10/15/25 for 107 pounds. For 10/22/25 and 10/29/25, there (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	was no weight' for those dates. For November, one weight was documented on 11/19/25 for 108 pounds. There were no weights documented for 11/5/25, 11/12/25, and 11/26/25. For December, one weight was documented for 12/3/25 for 106 pounds. There were no other weights or notes documented on the Weight Graph after 12/3/25. Review of resident #20's Provider Progress Note, titled, Dietary Consultation, dated 10/7/25, showed, The dietitian notes 'offer highest calorie supplement available.' She recommended that we add higher calorie foods to her foods and beverages such as heavy whipping cream and extra butter. [Resident #20] has been noted to have weight loss '11.2% in six months with BMI of 18.' This has been known since her fall and hip fracture. She is actually doing better with regard to her hip fracture, however. She is able to ambulate around and is less frustrated by life in general, it seems. Review of resident #20's Provider Progress Note, dated 12/30/25, showed, . [Resident #20] has not wanted to eat recently. She says today that she is not hungry and tears down a peanut butter and jelly sandwich. Staff noted she did not want to get up for breakfast. The assessment and Plan did not address the resident's weight loss. A review of the Provider Progress Notes, from 10/7/25 to 1/28/26, did not show any additional information for resident #20's severe weight loss in December 2025. b. Nutritional Assessments Review of resident #20's comprehensive Annual Nutrition Assessment, dated 8/2/25, showed, admit date : [DATE]. [height]: 65 [inches] Current weight: 115 [pounds on] 7/28, 6/23: 119 [pounds] [Ideal body weight]: 125 [pounds] (92%) Admit weight: 116 [pounds] and [Body Mass Index] 19. Current diet order: regular with supplement of choice between meals/bedtime. Extra butter/cream to appropriate foods. Meal intakes: 0-100%, needs supervision. Drinking 60-240 cc of supplement. Resident is at high nutritional risk due to dementia and recent fall with fractures. Weight is down 4 pounds in a month or 3%. [Body mass index] is low/normal range. Recommend supplement of choice [three times a day] with meals as well due to resident's new hip/wrist fracture. She does seem to like the supplements most of the time. [sic] Review of resident #20's Quarterly Mini Nutritional Assessment, dated 9/26/25, showed the resident's weight on 9/10/25 was 108 pounds. The resident had a moderate decrease in food intake, with a weight loss greater than 6.6 pounds over the last three months, and a BMI of less than 19. The evaluation showed the resident was malnourished with a score of 3. Review of resident #20's comprehensive Nutritional Quarterly Review note, dated 9/30/25, showed Resident eats independently. Meal intake: usually 76-100%. Diet order: regular diet with ground meat texture. Orders also include Ensure with meals and [bedtime]. Weight: 108.7# BMI 18. August weight 108.5 [pounds] March weight: 122.5 [pounds] Weight loss of 11.2% in 6 months is significant. Weight loss and BMI of 18 places patient at increased nutritional risk. Recommend offer highest calorie supplement available. Add extra butter / heavy whipping cream to appropriate foods/beverages. Review of resident #20's Quarterly Mini Nutritional assessment dated [DATE], showed the resident's weight on 12/18/25 was 103 pounds. The resident had a moderate decrease in food intake, with a weight loss between 2.2 and 6.6 pounds in the last 3 months, and a BMI of less than 19. The evaluation showed the resident was malnourished with a score of 5. A review of resident #20's electronic and paper medical record did not show any further (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	comprehensive quarterly nutritional assessments were completed after 9/30/25, besides the mini nutritional assessment on 12/22/25. On 1/28/26 at 3:30 p.m., a document request for dietary evaluations and/or assessments, including IDT notes for weight loss in the last six months, was provided to the facility. No further nutritional assessments or evaluations by the dietitians after 9/30/25 were provided by the facility by the end of the survey, 1/29/26. The facility failed to provide a nutritional assessment completed by the dietitian for resident #20 in December 2025 and or January 2026 to analyze and evaluate related factors for the severe weight loss in one month. c. Care Plan Revision Review of resident #20's Care Plan, with an initiation date of 9/27/24, and a revision date of 12/5/25, showed: Focus: The resident had unplanned/unexpected weight loss related to poor food intake after her recent pelvic and wrist fracture, and the weight loss was an ongoing problem. Goal: The resident will consume 100 percent of two of three meals/day, which was initiated on 9/27/24 and revised on 9/27/24. The resident's weight was also to return to the baseline weight range between 125 and 130 pounds by the review date. This goal was initiated on 9/27/24, with a revision on 8/1/25. The Interventions/Tasks showed the following for resident #20: - Current weight is 103 pounds. Date Initiated: 09/27/24 Revision on: 10/2/25. - Dietician will evaluate resident 8/2/25. Date Initiated: 8/1/25. - High calorie supplement after meals and at bedtime. Date Initiated: 12/5/25. - If weight decline persists, contact physician and dietician immediately. Date Initiated: 9/27/24. - Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss. Date Initiated: 9/27/24. - Monitor and record food intake at each meal. Date Initiated: 9/27/24. - Offer snacks between meals. Date Initiated: 8/1/2025. - Regular diet Date Initiated: 3/27/25. - Resident needs her meats mechanically altered. Date Initiated: 10/2/25. - Supplement of choice if resident skips a meal, add extra butter and heavy whipping cream to appropriate foods. Date Initiated: 11/6/24. Revision on: 3/27/25 - Weigh at same time of day and record: morning before breakfast once a week. Date Initiated: 9/27/24. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/28/26 at 11:39 a.m., staff member B stated that the dietitians review the residents for weight loss based on the list provided to them every month. After they complete the assessments, they provide staff member L with any recommendations or interventions, and staff member L notifies the provider of any order changes. Staff member B stated that staff member L would complete any care plan updates recommended by the dietitians. She stated that weight losses were monitored during the monthly care plan meetings. She stated the dietitians did not attend the care plan meetings. During an interview on 1/28/26 at 12:08 p.m., staff member L stated there were two dietitians who visited the facility once a month, and they rotate between them every other month. She stated that she would prepare a list of residents for the dietitians to review each month. She stated she had a book in which she tracks information on residents regarding weight changes. Staff member L stated that once the dietitians were done with their evaluations, if they had any recommendations, she would take those to the provider for orders. She stated she was not sure why resident #20 was not reviewed for a nutritional assessment by the dietitians for December 2025 or January 2026, other than she did not show as nutrition at risk. During an interview on 1/28/26 at 3:41 p.m., staff member B stated resident #20's weight had been stable, and the (EHR) system did not flag the resident for nutrition at risk. She stated every resident should be weighed weekly and the weights should be documented in the EHR. Staff member B stated she had asked staff member M about weights for resident #20 and was told by staff member M that he had seen resident #20 being weighed by the aide last week, but did not know why it was not documented in the resident's chart. Staff member B also stated they had two registered dietitians who rotated every other month, so one dietitian was at the facility each month. Staff member B said it was the expectation for the annual nutritional assessments to be completed yearly by the dietitians, and the quarterly nutritional assessments were to be completed by the dietitians at least every three months. She stated she was not certain why resident #20 did not have a comprehensive nutritional assessment by a dietitian in either December 2025 or January 2026. She stated that staff member H visited the facility in both December and January. Staff member B stated they have IDT meetings weekly and stated they discuss resident #20's nutritional concerns at those meetings, stating resident #20's weight had been stable. During an interview on 1/29/26 at 11:15 a.m., staff member H stated she had been to the facility once in December 2025 and again in January 2026. She stated she came once a month to complete nutritional reviews of residents. She stated that staff member L compiles the list of residents to be reviewed each month. Staff member H stated they completed annual and quarterly nutritional assessments for residents based on the information provided to them by staff member L. She stated she did not communicate directly with the provider. She stated after an assessment that if she had any recommendations, she would inform staff member L who would then notify the provider to obtain any physician order changes. She stated she did not write dietary orders. Staff member H stated she did not call to speak with the resident's family members regarding weight loss concerns, but would discuss any concerns if the family member was at the facility. She stated if she had any concerns regarding a resident, she would speak with staff member H, stating staff member L usually had a good idea what was going on with each resident, and would also review resident notes for information regarding the resident. She stated staff member L would notify her if there were any issues or concerns regarding a resident's nutritional status. Staff member H stated if a significant weight loss was identified, she would review a resident's percentage of weight lost in one, three, and six months and make recommendations and suggest interventions based on the weight loss. She stated she monitored the resident's weights based on her communication with staff member L and then reviewed (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	weights in the EHR. She stated she reviewed resident weights at least monthly, and if recent weights were not available, she would request the resident be reweighed as soon as possible. She stated she could not say if she reviewed resident #20's weight loss in December 2025 or January 2026 without looking at their EHR, and she did not have access at that time to review the information. Staff member H stated she did not attend the facility IDT meeting, the Nutrition at Risk meeting, any resident care conferences, or QAPI meetings. She stated she did not complete any care plan updates; those were completed by staff member L. Review of the facility policy titled, Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, last revised 9/2017, showed: 3.a. Dietary restrictions are not always essential, and they may even be unnecessary or harmful. In some instances the risk of continued weight loss and hydration deficits may outweigh other considerations that such restrictions are meant to address. Monitoring 1. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example additional weight gain or loss. 2. When medical conditions or medication-related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident/patient's responses.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement comprehensive, person-centered care plans for the use side rails for 2 (#4 and #8); failed to comprehensively care plan the use of enhanced barrier precautions for 1 (#7); and failed to implement care plan interventions to address an identified weight loss 1 (#6) of 20 sampled residents. The deficient practices increased the risk of negatively impacting the residents' quality of life. Findings include:1. During an observation on 1/26/26 at 4:20 p.m., a side rail was observed on the right side of resident #4's bed.Review of resident #4's comprehensive care plan, with an admission date of 9/11/25, failed to identify the use of side rails or include any related interventions, risks, or monitoring.2. During an observation on 1/26/26 at 4:19 p.m., two side rails were observed on resident #8's bed.Review of resident #8's comprehensive care plan, with an admission date of 10/16/25, failed to identify the use of side rails or include any related interventions, risks, or monitoring.During an interview on 1/28/26 at 11:44 a.m., staff member B said the use of side rails required a physician's order and side rails should be on the resident's care plan.3. During an observation and interview on 1/27/26 at 12:03 p.m., no personal protective equipment supplies or signage indicating infection control precautions were observed outside or inside resident #7's room. Resident #7 stated he did have a catheter in place.Review of resident #7's comprehensive care plan, with an admission date of 12/22/14, failed to identify the need for enhanced barrier precautions related to catheter use.During an interview on 1/29/26 at 10:50 a.m., staff member F stated that the use of enhanced barrier precautions should have been reflected on a resident's care plan.4. During an interview on 1/27/26 at 9:27 a.m., NF1 said he had a concern related to resident #6's intake and ongoing weight loss. NF1 stated he communicated these concerns to facility staff and requested that a nutritional supplement be provided to address the weight loss.During an interview on 1/28/26 at 10:52 a.m., staff member M stated that the kitchen distributed supplements and charted the intakes.During an interview on 1/28/26 at 11:29 a.m., staff member J said she was just informed of the physician's order for resident #6's supplement and revealed that before today, they were unaware she had an order for a supplement, and the resident had not been receiving the supplement.Review of resident #6's EHR revealed a nutrition/dietary progress note, dated 9/30/25, that documented the resident had experienced weight loss. The progress notes further showed NF1 requested a protein supplement due to the noted weight loss. The kitchen was made aware of the supplement, and supplements were to be implemented, with a recommendation to offer the highest-calorie supplement.Review of resident #6's physician orders showed, Dietary recommendations: Offer highest calorie supplement available, revised on 10/7/25.Review of resident #6's comprehensive care plan with an admission date of 11/15/15 showed, .Focus: The resident has nutritional problem or potential nutritional problem, history of obesity with weight loss. Resident has had an unplanned weight loss. Revision on: 5/2/24. Goal: The resident will not lose any more weight .Resident will return to 165 pounds as her goal weight, Revision on 5/2/24.Interventions/Tasks: .offer highest calorie supplement. Date Initiated: 12/5/25.Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, not dated, showed, Policy Statement, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure a Medication Aide II (MAII) in training had direct supervision of a licensed nurse while passing medications; and failed to ensure staff administered medications following the professional standards of medication administration rights for 3 (#s 1, 10 and 31) of 20 residents sampled. This deficient practice increased the risk of medication administration errors. Findings include: 1. Medication Aide II CertificationDuring an interview on 1/28/26 at 8:23 a.m., staff member N stated she was currently a CNA and had completed an online course for MAII. She stated she had not yet completed the test to be a MAII and was not yet certified.During an interview on 1/28/26 at 10:35 a.m., staff member N stated staff member M was the supervising nurse that day while she completed the medication pass. She stated she was allowed to administer medications without the direct supervision of a licensed nurse. Staff member N stated she was not sure exactly where staff member M was, stating, He could be anywhere at this point.During an interview on 1/28/26 at 10:39 a.m., staff member M stated he was the charge nurse for the day and would try to make himself available should staff member N need any assistance with their medication pass. He stated he was not given any direction on the need for direct supervision of staff member N.During an interview on 1/28/26 at 11:39 a.m., staff member B stated staff member N was currently in training for the MAII certification. She stated that while an aide was enrolled in the MAII curriculum, a nurse needed to be there to supervise them, but it was not necessary to stand over them while they completed their medication pass. Staff member B stated staff member N had not yet taken and/or passed the certifying test for the MAII certification.A facility document request for staff member N's Medication Aide II Certification was requested on 1/28/26 at 11:20 a.m. The document was not provided by the end of the survey.During an interview on 1/28/26 at 2:00 p.m., staff member A stated staff member N did not have a current MAII certification and was scheduled to take the certification testing on 1/29/26.2. Professional Standards of Medication AdministrationDuring an observation and interview on 1/28/26 at 8:23 a.m., staff member N poured a powder medication of MiraLAX in a small medication cup for resident #10. Staff member N then poured the powder medication into the resident's gray plastic drinking mug which was sitting on the resident's bedside table. She then stirred it with a straw and replaced the gray plastic lid. Staff member N stated the water mug was about one third of the way full of water. She could not state how much water in ounces was in the water mug1. Staff member N stated she would mix resident's MiraLAX in a resident's water mug or other beverage, stating, it's the best place to put it. Staff member N stated she would return every so often to make sure the resident had finished drinking the MiraLAX.During an observation on 1/28/26 at 8:44 a.m., staff member N entered the dining room during the breakfast meal. She poured a white powdered medication into resident #1's red colored juice and mixed in the medicated powder. Staff member N left the dining room and did not complete observing resident #1 to determine if she finished drinking all of the juice the white powdered medication was mixed in. During an observation and interview on 1/28/26 at 9:03 a.m., staff member N poured a white powdered medication into resident #31's honey thickened orange juice and stirred it. The honey thickened orange juice became thicker to the consistency of pudding. A bottle of Thick-it was on the dining room table. Staff member N stated she gave resident #31 his MiraLAX in the orange juice. She stated the MiraLAX can sometimes make a drink thicker. Staff member N left the dining room and did not ensure resident #31 finished drinking all the orange juice the MiraLAX was mixed in. During an interview on 1/28/26 at 10:39 a.m., staff member M stated MiraLAX could be mixed into water or juice and should usually be mixed with and administered with eight ounces of fluid. Staff member M stated it was important to ensure a resident completed medications before leaving. Staff member N stated the water mugs in the resident rooms should not be used for mixing medications.During an interview on 1/28/26 at 11:39 a.m., staff member B stated MiraLAX should be (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweet Memorial Nursing Home	125 Airport Rd Chinook, MT 59523

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mixed with the appropriate amount of fluid. She stated if the nurse was uncertain if a resident could finish the drink with the medication mixed in, the nurse should watch the resident to ensure they finished the medication. Staff member B stated it would not be recommended to mix MiraLAX into the resident's water mugs because it would be hard to monitor if they finished taking all of the medication. Staff member B stated if a resident was on a modified diet which required thickened liquids for swallowing, the nurse administering the MiraLAX would need to ensure the liquid was thickened to the prescribed thickness. Review of the facility's policy and procedure titled, Administering Medications, with no revision date, showed: 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions.10. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.1 MiraLAX Dosage Guide. Drugs.com, www.drugs.com/dosage/miralax.html. stir and dissolve one packet of powder (17 g) in any 4 to 8 ounces of beverage (cold, hot or room temperature) then drink.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure the infection prevention and control program was reviewed at least annually and failed to ensure current standards of practice were followed when enhanced barrier precautions were not implemented for residents with suprapubic indwelling catheters for 2 (#s 7 and 26) of 20 sampled residents. This deficient practice failed to ensure the current standards of practice were followed to prevent and control infections, and it increased the risk of transmission of multidrug-resistant organisms. Findings include:1. Annual Review A review of the facility's infection prevention and control program policies and procedures showed there was no documentation of an annual review. During an interview on 1/29/26 at 10:50 a.m., staff member F stated the policy review dates were reflected in the policy headers and showed that the Med Pass policies were the most recently reviewed. During an interview on 1/29/26 at 10:55 a.m., staff member A stated the Med Pass policies were reviewed when implemented in June of 2024. Staff member A stated that the infection control program policies had not been reviewed annually. 2. Enhanced Barrier Precautions a. During an observation and interview on 1/27/26 at 12:03 p.m., resident #7's room lacked signage indicating enhanced barrier precautions and personal protective equipment (PPE) outside or inside the room. Resident #7 stated he did have a catheter, and staff did not wear gowns when providing catheter care or any other care. During an interview on 1/28/26 at 9:25 a.m., staff member M stated that resident #7's catheter got clogged a lot. Staff member M stated standard precautions were used for resident #7's catheter care and required only the use of gloves. During an interview on 1/28/26 at 9:37 a.m., staff member Q stated resident #7 required assistance with draining his catheter bag, and the personal protective equipment (PPE) required included gloves and alcohol pads; gowns were not required. When asked about what personal protective equipment was required for the use of enhanced barrier precautions, staff member Q stated, What's that? During an interview on 1/29/26 at 10:50 a.m., staff member F said there was only one resident at the facility who required precautions, and the individual required precautions for MRSA (methicillin-resistant Staphylococcus aureus). Staff member F said enhanced barrier precautions were used for MRSA and required the use of gowns, face shield, and gloves. Staff member F said personal protective equipment should be used when providing any direct care to the residents. Staff member F gave examples of high contact care, such as dressing, bathing, nail care, direct contact, and transferring. Staff member F said personal protective equipment should be used anytime the resident who required enhanced barrier precautions was touched. Staff member F did not identify resident #7 as requiring enhanced barrier precautions despite his indwelling catheter. Review of resident #7's treatment administration record for January 2026 showed his suprapubic catheter was to be changed on the day shift every four weeks on Fridays for long-term catheter use, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and daily catheter flushes were ordered as needed. Resident #7's physician orders lacked any order addressing enhanced barrier precautions for the indwelling catheter. Review of resident #7's comprehensive care plan, with an admission date of 12/22/14, showed, .Focus: The resident has (indwelling Suprapubic) Catheter: r/t urinary retention as evidenced by urinary retention. Date Initiated 3/21/22. b. During an observation on 1/27/26 at 8:29 a.m., there were no enhanced barrier precaution signage or supplies posted outside of resident #26's room. Staff members P and Q were assisting resident #26 with toileting, utilizing a sit-to-stand lift. The resident had an indwelling catheter. Staff members P and Q were only wearing gloves; they were not wearing any additional PPE. During an interview on 1/27/26 at 9:29 a.m., staff member P stated she was not aware of any additional PPE needed when caring for a resident with an indwelling catheter. During an interview on 1/28/26 at 3:15 p.m., staff member Q stated she was not aware of any additional PPE needed when caring for a resident with an indwelling catheter. Review of resident 26's Physician Orders, dated 12/24/25, showed, Urinary Catheter Care- perform per-care with Redi cleanse peri wipes [every]shift and after [bowel movement]. Urinary Catheter supra pubic 16 [French] 10 [milliliter] bulb as needed for Occlusion or Leakage As Needed. Urinary Catheter supra pubic 16 [French] 10 [milliliter] bulb every day shift every 2 weeks on Wed change catheter bag with catheter change and every 2 [weeks]. Urinary Catheter supra pubic 16 [French] 10 [milliliter] bulb every day shift every 4 weeks on [Wednesday] Change catheter and bag every 4 weeks. [sic] Review of resident #26's Care Plan showed interventions for a suprapubic indwelling catheter but failed to address enhanced barrier precautions for the catheter care. Review of the facility's policy titled, Infection Control: Isolation Precautions, reviewed 2/22/24, showed, Purpose: To outline Isolation types and when to initiate isolation for a resident within the facility. To facilitate proper equipment, use, and implementation of isolation precautions. Staff need to recognize the type of isolation and appropriate personal protective equipment (PPE) by the signage used on resident doors. Enhanced Barrier Precautions: Enhanced barrier precautions (EBP) will be used in addition to standard precautions in the care of residents with indwelling medical devices or open wounds. EBP will not impede the movement of a resident within the facility and does not require a resident to remain in their room. Indwelling medical devices that may require the use of EBP include central venous catheters, Foley catheters, and suprapubic catheters. Open wounds that require wound care and dressing changes will require the use of EBP. EBP may be discontinued when the medical device is removed or the wound has resolved. PPE required for EBP: - Isolation gown (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Gloves - Eye protection/face shield if irrigation is required. [sic]

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on the observation, interview, and record review, the facility failed to ensure a physical restraint used for a resident with a seatbelt was used to treat a documented medical symptom, failed to assess the resident's ability to release the seatbelt, and failed to ensure the restraint was used for the least amount of time with appropriate monitoring and re-evaluation for 1 (#3) of 20 sampled residents. The deficient practice increased the risk for decreased mobility and injury. Findings include:During an interview on 1/27/26 at 10:45 a.m., NF2 stated resident #3's seat belt should be buckled when she was in the wheelchair. NF2 further stated, They say it's a restraint and that's what I want, I want her to stay off the floor.During an observation on 1/27/26 at 11:14 a.m., resident #3 was observed in a wheelchair positioned in a tilted backward/reclined position. A seat belt was present on the wheelchair; however, the belt was not fastened around the resident. The resident remained seated in the wheelchair during the observation.During an observation on 1/28/26 at 8:34 a.m., resident #3 was observed in a wheelchair positioned in a reclined/tilted backward position. A seat belt was fastened across resident #3's waist and secured to the wheelchair frame. The resident remained in the wheelchair and did not independently remove the belt during the observation.During an interview on 1/28/26 at 11:44 a.m., staff member B stated the seatbelt use for resident #3 was required for positioning and stated resident #3 had not been assessed for the ability to release the seatbelt independently and stated resident #3's hands were Not real strong.During an interview on 1/28/26 at 2:26 p.m., staff member K stated informed consents were obtained upon admission. Staff member K said there was no process in place to have the consents revisited if a resident experienced a decline or a change, or to monitor the effectiveness of the intervention of the informed consent.Review of resident #3's progress notes showed the following communication with family notes:7/1/25 at 3:01 p.m. - Call placed to [resident #3's family member] regarding [Resident #3's] wheelchair. Explained to [resident #3's family member] that the reason she needed the blue chair is because the Rock and Go does not accommodate her legs and feet. [Resident#3's family member] talked to this nurse regarding a Seat Belt. This nurse discouraged pursuit of that at this time. [Resident #3's family member] happy with the plan of care at this time. [sic]7/1/25 at 3:39 p.m. - New order to place seatbelt to rt's wheelchair d/t falls. Notified family member [name of resident #3's family member] and she is in agreement with this, will be here this afternoon to sign restraint consent. [sic]7/1/25 at 7:00 p.m. - [Name of resident #3's family member] in to sign Seat Belt restraint consent form and we also discussed prior order for OT for custom fit wheelchair. Pt. is private pay and family cannot afford the consult and new chair. They wish to decline at this time. Notified activities of cancelation plans. [sic]The progress notes show the family declined an occupational therapy assessment due to cost, and the seatbelt was implemented at the family's request without a documented safety or positioning assessment.Review of resident #3's acute physician visit progress note, dated 7/1/25, showed that resident #3 was seen for a fall on 6/28/25 when she fell out of a wheelchair. The progress note showed, We have been trying to find a more appropriate wheelchair for her, one that supports her feet and legs appropriately and that does not cause her to be leaning forward so much. Her family member is aware of this. Previous to that episode, we requested an OT consult for better fitting wheelchair for her.Plan: .Occupational therapy consult is needed for a better fitting wheelchair with foot supports for her. I will ask for a seatbelt to be used so she cannot fall forward again hopefully.Addendum: 1500 hours (3:00 p.m.) A little bit ago [Staff member O] with restorative physical therapy did bring by [Resident #3's] wheelchair. I asked specifically that foot supports be placed on her wheelchair every time it is used. I also asked that a seatbelt be placed.[Staff member E] would have to put a seatbelt on; she could not do that. I did ask that it be done. This is a safety issue related to fall. Again, I am hopeful that a formal occupational therapy and seating evaluation can be done for [Resident #3]. [sic]The progress note showed the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seatbelt was placed by the order of the physician, without an occupational therapy assessment, secondary to the resident's fall on 6/28/25.Review of the facility's document titled, Informed Consent for use of physical restraints, dated 7/1/25, showed the identified medical symptom, which indicated the restraint use for resident #3 was Seatbelt to wheelchair (DX: Fall), [NF2] refused OT referral for WC positioning eval. The risks assessed were immobility and skin breakdown. The less restrictive restraints that were not effective were adaptive furniture, restorative care, frequent monitoring by staff to identify toileting, pain or comfort, and assisted toileting. Other alternatives attempted were to assess for physical illness, including pain and infection, increase activities during the day, and attempt to reorient, reassure, and distract the resident. The document further noted, [NF2] refusal OT referral for wheelchair positioning. Pre-existing conditions that may predispose the resident to injury, such as impaired cognition or fall history, were included in the list. No preexisting conditions that may predispose the resident to injury were checked in the document for resident #3. The document further showed I request, under the management and supervision of my doctor, the use of: seat belt on wheelchair for the medical conditions specified by my doctor. [sic]The document lacked the assessment of the resident's ability to release the seat belt independently, failed to identify impaired cognition and history of falls as predisposing risk factors, did not specify the duration or monitoring of the seatbelt, and lacked an appropriate medical symptom for the use of the seatbelt; showing the diagnosis for the use of the seatbelt was a Fall.Review of resident #3's physician's order, dated 7/1/25, showed . 2. Seat belt to WC (DX: falls). The order did not include the duration or monitoring parameters for the use of the seatbelt.Review of resident #3's physician orders and care task list lacked monitoring of the effectiveness of the use of resident #3's seatbelt.Review of resident #3's Minimum Data Set, with an assessment reference date of 5/20/25, showed resident #3 had a BIMS score of 3, reflecting severe cognitive impairment.Review of resident #3's Minimum Data Set with an assessment reference date of 8/19/25 showed resident #3 had a BIMS score of 3, reflecting a severe cognitive impairment.Review of resident #3's care plan, with an admission date of 2/18/20, showed: . Focus: The resident has history of falls d/t Poor Balance, Unsteady gait, Date Initiated 2/28/22Goal: The resident will continue usual activities without incidence of falls through the review date. Revised on 2/25/25Interventions/Tasks:. Seatbelt while in wheelchair d/t a history of falls from her wheelchair. (Family refused OT referral for seatbelt evaluation) Date Initiated: 7/1/25.The care plan failed to include how the seatbelt was monitored for effectiveness, how long the seatbelt was to be used for, or the resident's ability to self-release the seatbelt.Review of the facility's policy titled, Use of Restraints, not dated, showed: Policy Statement.Restraints shall only be used to treat the resident's medical symptoms(s) and never for discipline or staff convenience, or for the prevention of falls.When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to:a. treat the medical symptom;b. protect the resident's safety; andc. help the resident attain the highest level of his/her physical or psychological well-being.6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.9. The order shall include the following:c. The type of restraint, and period of time for the use of the restraint.16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination.[sic]The policy confirmed restraints are not to be used for fall prevention, require a documented medical symptom, pre-restraint assessment, the duration for the use of the restraint and on-going re-evaluation and monitoring of the restraint.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it did not use psychopharmacological medications as chemical restraints, ensure medications were prescribed for appropriate diagnosis management, or provide informed consent for the medications for 1 (#2) of 20 sampled residents. Findings include:During an interview on 1/27/26 at 1:32 p.m., staff member B stated resident #2 was not appropriate for the facility as she had behaviors they could not handle. Staff member B stated they had several medications they used for behaviors, including multiple PRN psychotropic orders for Ativan and hourly ABH gel. Staff member B stated the facility was still figuring out what combination was right for resident #2 to keep staff safe from her behaviors, which was why the PRN orders had ranges and multiple orders available for nurses. Staff member B stated she was more aggressive in giving the PRN medications and higher doses because it did not have much effect on resident #2, but the floor nurses were more apprehensive about using anything other than the lowest doses. Staff member B stated they could not give resident #2 too many medications because they barely affected her.During an observation on 1/28/26 at 9:08 a.m., resident #2 was in the dining room, unable to stay awake, rocking herself back and forth in her wheelchair.During an observation on 1/29/26 at 10:48 a.m., resident #2 was in her room sleeping.Review of resident #2's EHR showed that on admission in July 2025, she did not take any medications and had a primary diagnosis of dementia in other diseases classified elsewhere, unspecified severity with agitation.Review of resident #2's MAR/TAR for January 2026 showed psychopharmacological medications of:-Exelon Transdermal Patch 9.5MG/24 HR Apply 1 patch transdermally every night shift for Dementia with behaviors, with a start date of 1/14/26, increased from 4.5 started on 10/8/25.-Seroquel Oral Tablet 25 MG (Quetiapine Fumarate) by mouth at bedtime for dementia, not before supper, with an updated date of 1/14/26, started on 10/28/25.- Ativan Oral Tablet 1MG (Lorazepam). Give 1 mg by mouth two times a day for Dementia with behaviors, anxiety, with a start date of 1/14/2026, prior to this date, it was three times a day with a start date of 10/28/25.-Namenda Oral Tablet 10 MG (Memantine HCl) given by mouth two times a day for dementia with an updated date of 1/13/26, started on 7/24/25.- ABH cream Apply to the inner forearm topically every 1 hour as needed for anxiety, agitation, aggressive behavior, lorazepam 1mg/ml; Haldol 2mg/ml, Benadryl 12.5mg/ml compounded cream in single-dose syringes, 1/2 ml dose with a start date of 8/28/25.- Ativan Oral Tablet 0.5 MG (Lorazepam) Give 0.5 mg by mouth every 4 hours as needed for agitation (may give 0.5 mg to 1 mg) with a start date of 10/21/25- Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 mg by mouth every 4 hours as needed for agitation 0.5 mg-1 mg with a start date of 10/21/25. A request was made on 1/29/26 for resident #2's psychoactive medication consents. The only documentation provided was a printout of a late entry progress note backdated to 1/28/26, entered into the EHR after the request was made, showing, . POA [Name] in attendance for family care conference. Discussed resident's behavior, mobility, weight, activity attendance, and current medications. POA in agreement with current plan of care with no concerns noted at this time.There was no medication consent showing the diagnosis with risks and benefits found or provided for resident #2's current medication ordersReview of the facility policy, Antipsychotic Medication Use, last revised July 2022, .16. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use . not due to environmental stressors (e.g. hunger . excessive noise for that individual, inadequate or inappropriate staff response. or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g. the mistaken belief that this is not where he/she lives.

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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. Based on interview and record review, the facility failed to update care plan goals and interventions for 1 (#2) for interventions for psychotropic medication use and 1 (#15) for severe weight changes of 20 sampled residents. Findings include:1. During an interview on 1/27/26 at 1:36 p.m., staff member B stated the facility had weekly care plan meetings and the facility had IDT meetings, however, resident #15 had not been identified as having a weight loss so she was not monitored by IDT or had an update in her care plan.Review of resident #15's EHR weights in pounds for August 2025 to January 2026, showed the resident has a severe weight loss of 17% in 6 months, with a 17% weight loss in the last six months and a 9.75% weight loss in the last three months. -8/4/25, 174.0-11/3/25, 159.5-1/19/26, 143.5Review of resident #15's Care Plan, last updated 6/5/25, showed a focus area for unplanned/unexpected weight loss due to sleeping and refusing to get out of bed, with a goal of maintaining a weight of 169 pounds through the 6/2/26 review.2. During an interview on 1/27/26 at 1:33 p.m., staff member B stated the facility had multiple PRN psychotropic medication orders to use in conjunction with scheduled medications to manage resident #2's behaviors. Staff member B stated the PRN Ativan had a range for nurses to use. The staff member could not explain what the parameters were for the nurses to determine which dose to use. Staff member B stated there was no ordered limit on the amount of PRN Ativan and PRN hourly ABH gel because the medications did not have much effect on resident #2.Record review of resident #2's Care Plan, last revised 10/25/25, showed a focus area of Daily use of antipsychotic medications r/t dementia behaviors affecting her safety. The goal was to have minimal behaviors regarding attempting to elope, and staff will be able to redirect the resident with inappropriate behaviors and exit-seeking. The only intervention listed was to monitor for side effects and the effectiveness of the medication.Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, last revised March 2022: . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents condition change.12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition;b. when the desired outcome is not met; at least quarterly.

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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** Based on observation, interview, and record review, the facility failed to assess a resident for safety with smoking and failed to develop a smoking care plan for 1 (#20) of 20 residents sampled. This deficient practice had the potential to affect the safety of all residents who smoked. Findings include:During an interview on 1/28/26 at 4:07 p.m., staff member P stated resident #20 sometimes went out to smoke with her family when they visited. She stated resident #20 would also go out with the other residents during the designated smoking times. During an observation and interview on 1/29/26 at 4:10 p.m., staff member N stated resident #20 sometimes went out to smoke with the other residents who smoked during the supervised smoking times. Staff member N showed resident #20's cigarettes and lighter that were locked inside the medication cart. A document request for resident #20's smoking care plan and smoking safety assessment was submitted to the facility on 1/28/26 at 4:30 p.m. No documentation was provided by the end of the survey.During an interview on 1/29/26 at 9:04 a.m., staff member A stated she searched back to resident #20's admission [DATE]), and they did not have a smoking safety assessment or a smoking care plan for the resident. Staff member A stated resident #20 should have a smoking safety evaluation/assessment and a smoking care plan completed. She stated it was the expectation to complete a smoking risk assessment and care plan for any residents who smoke. A review of the facility's Smoking Policy - Residents, with a review date of 7/23/25, showed: .6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: a. current level of tobacco consumption. b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); c. desire to quit smoking; and d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation).7. The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation.8. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff.9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues .11. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to identify and implement interventions to prevent triggers contributing to the overstimulation of the resident who had dementia; and implement the least restrictive and effective interventions for corresponding dementia behaviors, for 1 (#2) of 20 sampled residents. Findings include:During an observation and interview on 1/27/26 8:44 a.m., resident #2 was alone behind the nurses' station trying to reach the phone. Resident #2 attempted to stand to get the phone when a male resident who was vocally calling out was placed directly in front of the nurses' station with no staff present. Resident #2 was overwhelmed by the noise placing her head in her hands, shaking her head, and grumbling that she just needed to get away from the noise and she needed to call her mother so she could go home.During an observation on 1/27/26 at 8:57 a.m., resident #2 was behind the nurses' station attempting to reach and use the phone. Eight other residents were parked in the area, television on, with no staff present.During an observation on 1/27/26 at 9:09 a.m., in the dining room, resident #2's breakfast tray was on a table. There was one piece of buttered toast cut in half, open jam packet, coffee, water, juice, a sliced banana, and a bowl of soggy cereal that had begun to dry and had become crusty on top. The tray was later cleared without resident #2 having eaten breakfast. During an observation on 1/27/26 at 9:13 to 9:17 a.m., staff member G was sitting next to resident #2 behind the nurses' station. This surveyor inquired if resident #2 had eaten breakfast, and no staff answered; resident #2 could not recall. Resident #2 was asking to get help using the cordless phone in her hand, and staff member G was stating the phone was busy and they needed to give it a few minutes before trying to call again. When resident #2 asked again, staff member G told resident #2 she could go home on a bus in two hours if she wanted to take a catnap until then. Resident #2, in her wheelchair, then left the nurses' station, wandering past the queue of residents in wheelchairs and dining chairs, and set off the side exit door alarm. A different staff member walked to resident #2, stating ?What are you doing [Resident #2's name]?' Resident #2 stated she was trying to go home. The staff member began pushing resident #2 back to park her wheelchair at the nurses' station, and her feet were dragging on the floor.During an observation on 1/27/26 at 9:23 a.m., resident #2 was wandering at the nurses' station when a staff member gave her a bag of crackerjacks to eat and walked away. Resident #2 proceeded to eat the food while trying to pick up the dropped prize. No staff were present. Resident #2 was asking other residents about going home but was no longer wandering.During an observation on 1/27/26 at 4:27 p.m., resident #2 was wandering and set off the front entrance Wanderguard alarm. A staff member came down the hall to reset the alarm and wheel resident #2 back down the hallway.During an interview on 1/27/26 at 1:18 p.m., staff member B stated resident #2 was not appropriate for the facility, and they were not equipped for her behaviors of wandering and being aggressive. Staff member B stated the facility nurses did not have a limit on the amount of the PRN psychotropic medications to sue as they could not give resident #2 too much psychotropic medications due to the medications having little effect on her. Staff member B stated resident #2 wandered so much that the facility staff were now directed to let her get out of the doors and they followed her.Review of resident #2's Care Plan area of behavior problem., last updated 9/20/25, showed to:- anticipate and meet the resident's needs,- caregivers to provide opportunity for positive interaction, attention, and to stop and talk as passing by,- minimize potential for the resident's disruptive behaviors (combative behavior, elopement attempts, cursing, ramming others with wheelchair) by offering tasks which divert attention such as (looking at pictures, cup of coffee, walking),- monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes,- resident may go out the doors, if exit seeking persists, with the chaperone of one staff member. Other staff members need to be aware .- wander guard on at all times to prevent eloping .Review of facility policy titled, Dementia-Clinical Protocol, (continued on next page)

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	275127	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweet Memorial Nursing Home	125 Airport Rd Chinook, MT 59523

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last revised 11/2018, showed, .The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia. staff will review the effectiveness and complications of medications used to try to enhance cognition and manage behavioral and psychiatric symptoms and will adjust, stop, or change such medications as indicated.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observation, interview, and record review, the facility failed to ensure it did not use psychopharmacological medications as chemical restraints, ensure medications were prescribed for appropriate diagnosis management, and provide informed consent for the medications for 1 (#2) of 20 sampled residents. Findings include:During an interview on 1/27/26 at 1:13 p.m., staff member B stated the PRN antipsychotic renewal would be the responsibility of the charge nurse or nurse assigned to follow the provider on rounds to get them done that day. Staff member B stated the provider would normally write specific parameters for not giving specific medications concurrently or the maximum dose in a timeframe. The orders would be in the hard chart for each resident, as it was a lot to change the orders in the EHR every time. Staff member B stated for resident #2 the PRN ABH gel was probably due for renewal but in her case, there was not going to be an overdose or ?snow' cannot give her too much as they could barely manage her symptoms. The dose range and amount of PRN medications were due to the provider being unsure of the appropriate dosage to work for resident #2, and it should not be a range without parameters, but staff member B stated she had prescriptive authority. Staff member B stated the floor nurses could give either dose of the Ativan tablets, and in conjunction with the PRN ABH gel, but they usually used the lower dose as they were uncomfortable with going to the higher doses. During an observation on 1/28/26 at 8:10 a.m., staff member M prepared the following medications for resident #2. One lorazepam (Ativan) 1 mg tablet, one gabapentin (Neurontin) 600 mg tablet, and one memantine (Namenda) 10 mg tablet. Staff member M then approached resident #2, who was asleep, sitting in her wheelchair by the nurses' station. Staff member M attempted several times to wake resident #2 for her to take her medications. The resident would wake up for a second, look around, and fall back to sleep. Eventually, staff member M was able to rouse resident #2 to stay awake long enough to take the prepared medications. After taking the medications, the resident fell back to sleep while sitting in her wheelchair. Another staff member started to push the resident in her wheelchair to the dining room. The resident remained asleep.During an observation on 1/28/26 at 9:08 a.m., resident #2 was in the dining room unable to stay awake.During an interview on 1/29/26 at 10:37 a.m., staff member M stated he would try to use the least amount of PRN psychotropic medications for residents, especially resident #2, as he had experience in mental health centers and did not want to exacerbate behaviors. Staff member M stated that when he administered a PRN medication to a resident, he would watch the resident to make sure it was effective, but he did not document a progress note on the resident's behavior. Staff member M stated he believed the CNA charting was somehow linked to the medication use for behavior monitoring. Staff member M stated he only knew of Tylenol, or outside providers, putting specific parameters on medications to not give too much in a specific timeframe. When asked about administering ABH gel, staff member M stated he had never been provided guidance by the facility regarding other side effects or adverse reactions associated with anti-psychotics, or for monitoring the resident for adverse side effects after administering PRN psychotropic medications.Review of resident #2's MAR/TAR for January 2026 showed PRN psychotropic medications of:- ABH cream Apply to Inner forearm topically every 1 hours as needed for anxiety, agitation, aggressive behavior lorazepam 1mg/ml; Haldol 2 mg/ml, Benadryl 12.5 mg/ml compounded cream in single dose syringes. 1/2 ml dose with a start date of 8/28/25.- Ativan Oral Tablet 0.5 mg (Lorazepam) Give 0.5 mg by mouth every 4 hours as needed for agitation (may give 0.5 mg to 1mg) with a start date of 10/21/25.- Ativan Oral Tablet 0.5 mg (Lorazepam) Give 1 mg by mouth every 4 hours as needed for agitation 0.5mg-1mg with a start date of 10/21/25. - Resident #2 was given two ABH gel doses on 1/26/26 at 3:00 p.m., and 4:00 p.m., and 0.5 mg PRN Ativan at 6:34 p.m., by staff member B. Resident #2 was given two doses of ABH gel on 1/27/26 at 3:34 p.m., and 7:53 p.m. Observations of being overly sedated and hard to rouse were noted on 1/27/26, 1/28/26, observations.- There were no parameters for which dose or limit to give when combining with scheduled medications in a given timeframe. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #2's EHR showed that on admission in July 2025, she did not take any medications and had a primary diagnosis of dementia in other diseases classified elsewhere, unspecified severity with agitation. There were no other psychiatric diagnoses, anxiety, depression, or mood disorders.A request for psychotropic medication informed consents for resident #2 was requested on 1/28/26, and none were provided by the end of the survey.Review of the facility policy titled, Tapering Medications and Gradual Drug Dose Reduction, last revised July 2022, showed, 14. Attempted tapering of sedatives and hypnotics shall be considered as a way to demonstrate whether the resident is benefitting from a medication or might benefit from a lower or less frequent dose. Tapering shall be done consistent with the following: a. For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the physician shall attempt to taper the medication at least quarterly unless clinically contraindicated. [sic]Review of the facility policy, Antipsychotic Medication Use, last revised July 2022, showed: .16. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order.11. d. not due to environmental stressors (e.g. alteration in the residents customary location or daily routine, unfamiliar caregiver, hunger or thirst, excessive noise for that individual, inadequate or inappropriate staff response, physical barriers) that can be addressed to improve the psychotic symptoms or maintain safety; and,e. not due to psychological stressors (e.g. loneliness, taunting, abuse), or anxiety or fear stemming from misunderstanding related to his or her cognitive impairment (e.g. the mistaken belief that this is not where he/she lives or inability to find his or her clothes or glasses) that can be expected to improve or resolve as the situation is addressed.Review of facility policy titled, Dementia-Clinical Protocol, last revised 11/2018, showed, .The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia. staff will review the effectiveness and complications of medications used to try to enhance cognition and manage behavioral and psychiatric symptoms and will adjust, stop, or change such medications as indicated.

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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. Based on observation, interview, and record review, the facility failed to obtain routine dental care to meet the needs of a resident who had poorly fitted dentures for 1 (#8) of 20 sampled residents. This deficient practice resulted in the resident remaining without usable dentures and placed the resident at risk for decreased oral intake and weight loss. Findings include:During an observation and interview on 1/27/26 at 8:53 a.m., resident #8 was observed to be edentulous, with one natural tooth present and not wearing any dentures.During an interview on 1/28/26 at 12:50 p.m., staff members D and R stated they did not receive a referral for resident #8 to be seen by the dentist or denture clinic. Staff member D noted the denture clinic providers were in the facility on 1/12/26, seeing residents.During an interview on 1/28/26 at 1:24 p.m., staff member K was asked about resident #8's dentures and the status of the repair. Staff member K stated resident #8's family had her dentures, she had not been seen by the denture care clinic, and the staff would get her lined up for an appointment with the denture clinic. Staff member K said she had a hard time keeping in contact with family and reported that resident #8 went out with family on therapeutic leave. Staff member K stated resident #8's family would have to check in with the nursing department to get resident #8's medications and to check her out of the facility.During an observation and interview on 1/29/26 at 10:27 a.m., resident #8 nodded yes when she was asked if she wanted her dentures repaired. When asked if her dentures were with family, she nodded, no. Staff member O stated, I didn't know you had dentures, demonstrating a lack of staff knowledge regarding the resident's dental needs and equipment. Resident #8 motioned to her room, and staff member O went to resident #8's room and found the dentures beside the resident's sink.Review of resident #8's baseline care plan with an admission date of 4/10/25 showed resident #8 had dentures, and it was noted on the baseline care plan, Does not have with her though - family has for repairs. [sic]Review of resident #8's comprehensive care plan with an admission date of 10/16/25 showed, .Focus: The resident has a nutritional problem, is diabetic and has no teeth. Right sided CVA, Date initiated: 4/17/25.Goal: Resident will get her dentures fixed as soon as possible. Date Initiated 4/17/25.There were no interventions or tasks listed to complete the goal to get her dentures fixed as soon as possible, as it related to resident #8's nutritional problem.Review of the facility's document titled [Facility Name] Nutrition Report, for the week of 1/27/26, showed resident #8 had decreased intake and a weight loss of 3.5 lbs.Review of resident #8's Minimum Data Set with an Assessment Reference Date of 4/16/25 showed, Section L0200 Dental, A. Broken or loosely fitting full or partial denture, the box was checked yes.Review of resident #8's Minimum Data Set, with an Assessment Reference Date of 1/13/26, showed under Section L0200 Dental, A. Broken or loosely fitting full or partial denture, the box was checked no.A request was made for resident #8's dental appointment and dental progress notes on 1/28/26 at 4:22 p.m. No documentation was provided before the end of the survey.Review of the facility's policy titled, Dental Services, not dated, showed, Routine and Emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.Policy Interpretation and Implementation1. Routine and 24-hour emergency dental services are provided to our residents through:a. a contract agreement with a licensed dentist that comes to the facility monthly;b. referral to the resident's personal dentist;c. referral to community dentists; ord. referral to other health care organizations that provide dental services.6. Social services representatives will assist resident with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible.10. If dentures are damaged or lost, resident will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay. [sic]Review of the facility's policy titled, Dental Examination/Assessment, not dated, showed, Policy Statement, Each resident shall undergo a dental assessment prior to or within ninety (90) days (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of admission.Policy Interpretation and Implementation,1. Resident shall be offered dental services as needed.2. Dental Examinations will be made by the resident's personal dentist or by the facility's consultant dentist.3. Records of dental care provided shall be made a part of the resident's medical record.4. Upon conducting a dental examination, a resident needing dental services will promptly referred to a dentist. [sic]

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on observation, interview, and record review, the facility failed to ensure an occupational therapy evaluation was completed to assess wheelchair positioning and the need for a seatbelt following resident falls and instead implemented a seatbelt without the proper evaluation when the family declined therapy due to the cost, for 1 (#3) of 20 sampled residents. The deficient practice resulted in the use of a positioning device without an appropriate assessment to ensure the resident's safety and effectiveness. Findings include:During an interview on 1/27/26 at 10:45 a.m., NF2 stated resident #3's seat belt should be buckled when she is in the wheelchair. NF2 further stated, They say it's a restraint and that's what I want, I want her to stay off the floor.During an observation on 1/27/26 at 11:14 a.m., resident #3 was observed in a wheelchair positioned in a tilted backward/reclined position. A seat belt was present on the wheelchair; however, the belt was not fastened around the resident. The resident remained seated in the wheelchair during the observation.During an observation on 1/28/26 at 8:34 a.m., resident #3 was observed in a wheelchair positioned in a reclined/tilted backward position. A seat belt was fastened across resident #3's waist and secured to the wheelchair frame. The resident remained in the wheelchair and did not independently remove the belt during the observation.During an interview on 1/28/26 at 8:52 a.m., when staff member A was asked about resident #3's need for an occupational therapy referral, she stated the evaluation was not a billable expense through Medicare and the resident was private pay; therefore, the family would have to pay out of pocket for the occupational therapy evaluation.The facility failed to obtain the necessary occupational therapy services despite the resident's payor or insurance, and the facility relied on family refusal rather than ensuring the resident's clinical needs were assessed and addressed.Review of an email addressed to staff member B from staff member U, dated 6/11/25 at 11:00 a.m., showed, an order was received from the physician for resident #3's wheelchair evaluation. The email further showed, Doesn't look like she has Medicaid but wanted to double check with you. Just so you know for future, if a LTC patient does not have Medicaid, it will not be covered under Insurance. If family is interested in private pay-we need to talk to them prior to setting up an eval. Documented on the copy of the email was a handwritten note showing resident #3's family requested to cancel the occupational therapy appointment.Review of resident #3's progress notes showed the following communication with family:7/1/25 at 3:01 p.m. - Call placed to [#3's Family member] regarding [Resident #3's] wheelchair. Explained to [Family member] that the reason she needed the blue chair is because the Rock and Go does not accommodate her legs and feet. [Resident#3's family member] talked to this nurse regarding a Seat Belt. This nurse discouraged pursuit of that at this time. [Resident #3's daughter] happy with the plan of care at this time. [sic]7/1/25 at 3:39 p.m. - New order to place seatbelt to rt's wheelchair d/t falls. Notified daughter [name of resident #3's daughter] and she is in agreement with this, will be here this afternoon to sign restraint consent. [sic]7/1/25 at 7:00 p.m. - [#3's Family member] in to sign Seat Belt restraint consent form and we also discussed prior order for OT for custom fit wheelchair. Pt. is private pay and family cannot afford the consult and new chair. They wish to decline at this time. Notified activities of cancelation plans. [sic]The progress notes show the family declined an occupational therapy assessment due to cost and the seatbelt was implemented at the family's request without a documented safety or positioning assessment.Review of resident #3's acute physician visit progress note, dated 7/1/25, showed that resident #3 was seen for a fall on 6/28/25 when she fell out of a wheelchair. The progress note showed, We have been trying to find a more appropriate wheelchair for her, one that supports her feet and legs appropriately and that does not cause her to be leaning forward so much. Her daughter is aware of this. Previous to that episode, we requested an OT consult for better fitting wheelchair for her. Plan: .Occupational therapy consult is needed for a better fitting wheelchair with foot supports for her. I will ask for a seatbelt to be used so she cannot fall forward again hopefully. Addendum: [3:00 p.m.] A little bit ago [staff member O] with restorative physical (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy did bring by [Resident #3's] wheelchair. I asked specifically that foot supports be placed on her wheelchair every time it is used. I also asked that a seatbelt be placed. [Staff member O] noted that [staff member E] would have to put a seatbelt on; she could not do that. I did ask that it be done. This is a safety issue related to fall. Again, I am hopeful that a formal occupational therapy and seating evaluation can be done for [Resident #3]. [sic]Despite the lack of an occupational therapy evaluation, a seatbelt was placed on the resident's wheelchair by order of the physician. No documented assessment addressed the proper fit and positioning, the impact on the resident's mobility, or the resident's ability to tolerate or safely use the device. The seatbelt was implemented without the specialized clinical assessment required to determine appropriateness. The facility failed to obtain the necessary occupational therapy services despite the resident's payor or insurance, and the facility relied on the family's refusal rather than ensuring the resident's clinical needs were assessed and addressed.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Facility Assessment was reviewed and updated annually, and when necessary to update memorandums of understandings for laboratory services, and emergency operations plan. This deficient practice increased the risk of negative outcomes for residents residing at the facility. Findings include:Review of the facility's Facility Assessment updates showed: - 10/2025: [staff member G] to help review/update.- 12/2025: name updates, [etcetera].- 1/2026: [staff member G] suggested updated [NAME] with [name of local hospital] for lab. Also, need updated [NAME] for EOP evacuation to [name of local hospital].Review of the facility's Facility Assessment did not show the facility's assessment was updated since September 2024 and suggested updates for 2025 and 2026 were not completed.During an interview on 1/29/26 at 8:13 a.m., staff member A stated she needed some help on updating the Facility Assessment. She stated staff member G had reviewed the assessment and made some suggestions, but they have not been able to complete the facility assessment for 2025.