STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275129	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immanuel Skilled Care Center	185 Crestline Ave Kalispell, MT 59901

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews and record review, the facility failed to ensure a resident is free from physical restraints, failed to identify a seatbelt as a restraint, failed to assess for safety for the use of a physical restraint prior to the placement of the restraint, and failed to ensure the use of a physical restraint was used to treat a resident's medical symptoms for 1 (#5) of 13 sampled residents. This deficient practice caused the resident to be restrained to her wheelchair by a seatbelt without a clinical rationale. Findings include:During an observation on 8/18/25 at 3:42 p.m., resident #5 was seated in her wheelchair in a small room near the dining area on the memory care unit. Resident #5 was observed to have a seatbelt in use in her wheelchair. During an interview on 8/18/25 at 3:44 p.m., staff member D stated resident #5 had a seatbelt on. Staff member D stated, she believed resident #5 could remove the seatbelt independently. During an interview on 8/18/25 at 3:55 p.m., staff member E stated she noticed resident #5 was wearing a seatbelt. Staff member E stated she was unaware why resident #5 was wearing a seatbelt. During an interview on 8/18/25 at 4:00 p.m., staff member F stated resident #5 was wearing a seatbelt because she had a tendency to fall out of her chair. Staff member F said resident #5 could not remove the seatbelt independently.During an interview on 8/19/25 at 2:53 p.m., NF2 stated she noticed the seatbelt about two months ago when she came to visit resident #5. NF2 said she had not been notified of the seatbelt placement or given consent for the use of the seatbelt. NF2 stated she believed the seatbelt was used to help her sit there and not fall, and stated resident #5 would not be able to remove the seatbelt independently. Review of resident #5's physician's orders showed no order for the use of a seatbelt.Review of resident #5's significant change MDS with an assessment reference date of 6/13/25, showed under section C, cognitive patterns, the resident was staff assessed for cognition due to the resident being rarely/never understood. Section P, physical restraints, showed no restraints used for resident #5.Review of resident #5's EHR showed a progress note dated 8/19/25 at 4:13 p.m., writer placed call to daughter discussed current wheelchair as chair belongs to resident. Discussed if seat belt on chair came with the chair daughter does not remember if it originally came on the chair. She was aware that the seatbelt has been used as it has been in place during her visits. Discussed therapy evaluated today for positioning and safety and would like to move forward with possibly changing out wheelchair. Also discussed removing the seat belt from the chair at this time. Daughter is in agreement. Will notify therapy to reach out to her as she shared her eye sight and cognition do not communicate with each other, explaining that when her chair gets caught up on a turn and she can't get away she will just get up and that is when she will fall. Work order also placed to removed the seatbelt from the wheelchair. [sic]Review of resident #5's Occupational Therapy note, titled Outpatient Clinic OT Eval and Plan of Treatment, dated 8/19/25, showed, .Seating/Mobility System Recommendations and Medical Necessity, Limitations, Current Impairments: Patient exhibits considerable balance impairments, is high risk for falls and recurring injury, is not a functional ambulator, Patient is non-ambulatory; cannot perform any form of self-ambulation nor assisted ambulation and Patient presents w/ mobility limitation restricting ability to participate in 1 or more ADLs.Examination/Functional Description: Resident was previously screened in May following report of forward falls from her wheelchair. At that time, her wheelchair cushion was found to be positioned backwards and was corrected. No further issues had been reported until a recent state visit, during which it was noted that staff had been using a seat belt with the resident. Resident does not demonstrate a clinical need for a seat belt at this time. [sic]A request was made for consent for seatbelt use for resident #5 on 8/19/25 at 4:43 p.m. No documentation was provided prior to the end of survey.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to report their investigative findings of a facility reported incident to the State Survey Agency in a timely manner for 7 (#s 1, 2, 3, 4, 5, 6 and 7) of 13 sampled residents. Findings include:1. Review of a facility-reported incident, dated 12/4/24, involved an allegation of an injury of unknown origin, where a 2.5 cm bruise was noted on resident #2's right deltoid. Review of the facility-reported incident findings, submitted on 12/13/24, showed resident #2 is on a blood thinner, is at high risk for bruising, and the bruise was noted on the deltoid where the blood pressure cuff would be placed. Resident #2 had blood pressure checks every morning by unit staff and 5 days a week with therapy.2. Review of a facility-reported incident, dated 12/11/24, involved an allegation of an injury of unknown origin, where a skin assessment revealed resident #4 had a 12 cm x 11cm bruise in various stages of healing on the resident's right lower rib cage extending to the right iliac crest. Resident #4 has a diagnosis of dementia, was unable to state how it occurred. Resident #4 had a documented fall on 12/1/24. Review of the facility-reported incident findings, submitted on 12/22/24, showed resident #4 has a history of falls due to self-transfers. Resident #4 also stood and walked without assistance. Resident #4 completed therapy services and participated in restorative walking with a gait belt, which would align with the area a gait belt would be placed.3. Review of a facility-reported incident, dated 12/11/24, involved an allegation of an injury of unknown origin where resident #3 was noted to have a purple-colored bruise below the eye where her glasses laid on her face. Review of the facility reported incident findings, submitted on 12/22/24, showed resident #3 was observed leaning on her right elbow with her head over her cup on her bedside table. The investigation concluded the bruise originated from resident #3's glasses while sleeping with head down on bedside table. 4. Review of a facility-reported incident, dated 3/21/25, showed resident #1 was found next to her bed and had blood on her face. Resident #1 was actively bleeding from both nares, had an open area to her lower gum, and a small cut on her right cheek. Facility staff obtained vital signs and a neurological examination. Resident #1's family and the provider were notified. A physician's order was received to send resident #1 to the emergency room for evaluation and treatment. Review of the facility reported incident findings, submitted on 3/31/25, showed resident #1 has a history of traumatic brain injury, cerebrovascular accident with right hemiparesis and aphasia, seizure disorder and migraine headaches. Resident #1 has a history of self-transfer attempts. CNA reported she was in resident #1's room ten minutes prior to fall and the CNA assisted the resident to bed. Approximately 10 minutes later CNAs came back to find resident on her right side on the floor next to bed with swelling and bleeding to her nose. At that time, resident #1 stated she hit her face on assist bar. The facility reported incident documentation showed resident #1 may have attempted to sit herself up on the side of bed, lost balance, hit her face on the assist bar and slid off the bed. Resident #1 was seen in the emergency room and evaluated. Resident #1 was positive for a urinary tract infection.5. Review of a facility reported-incident, dated 6/2/25, showed resident #5 and resident #6 were involved in a physical exchange in the hallway. No noted injuries, and staff immediately intervened. Skin checks were completed and alert charting was put into place for both residents. Review of the facility-reported incident findings, submitted on 7/11/25, showed both residents have a diagnosis of dementia and were unable to state what occurred during the incident. Resident #6 was to be within line of sight when both residents are in the same area. Referral made to another facility for resident #6. Care plans were updated.6. Review of a facility reported-incident, dated 6/9/25, showed resident #7 sustained a fall on 6/1/25, where she fell when a CNA let go of the resident momentarily to grab a personal item. Neurological exam was initiated at the time of event. Review of the facility reported findings, submitted on 6/18/25, showed the CNA had responded to resident #7's adamant request for a personal item. The CNA reported a gait belt was not used, and a review of the transfer status was conducted. The transfer card in resident #7's room did not specify a gait belt, and the status was updated to show gait belt for transfers. X-ray showed no findings.7. Review of a facility reported-incident, dated 7/9/25, showed an incident of an injury of unknown origin, where during a weekly skin assessment resident #5 was found bruising and swelling to right foot. The provider was notified and x-ray requested. A podus boot was applied for comfort. Review of the facility reported findings, submitted on 7/21/25, showed resident #5 self-propelled in wheelchair, wore nonskid socks or soft slippers and rocked back and forth when in wheelchair. Staff interviewed the resident and found no findings of change in routine or increased pain. Resident #5 had the potential to run her toes over with her wheelchair secondary to the advanced dementia and soft footwear During an interview on 8/19/25 at 1:30 p.m., staff