

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>41951</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were safe to self-administer medications before leaving the medications at the bedside, causing an increased potential for medications not being taken as the physician ordered, for 3 (#s 9, 23, and 48) of 37 sampled residents. Findings include:</p> <p>1. During an observation and interview, on 10/22/24 at 8:44 a.m., resident #48 was seated in a chair, next to her bedside table, waiting for her breakfast to be delivered. A medication cup with several pills was on the bedside table. Resident #48 stated the nurses sometimes left the medications for her to take on her own, if she had not received her food/meal when nursing staff were in her room to pass medications.</p> <p>During an interview on 10/23/24 at 8:33 a.m., staff member Q stated medications were not left at a residents' bedside for self-administering medication unless it was determined by an assessment, and they were safe to self-administer them. She stated if medications were seen at the bedside of a resident, then there was a self-administration order in place.</p> <p>Review of resident #48's document titled, Self-Administration of Medication, dated 2/8/23, showed:</p> <ul style="list-style-type: none"> <li>- . 23. Resident is approved for self-administration of medications b. No, and</li> <li>- 24. Resident may keep meds at bedside b. No.</li> <li>- Resident #48 was not approved for self-administration of any medications.</li> </ul> <p>41952</p> <p>2. During an observation and interview, on 10/22/24 at 8:48 a.m., resident #23 was observed in her wheelchair, with a breakfast tray on her bedside table, in front of her. On the tray was a full medicine cup of various medications. Resident #23 stated the medications were just left on her tray.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/24/24 at 9:04 a.m., staff member O stated resident #23 preferred her medications when her breakfast tray was delivered. Staff member O stated it would depend on the day whether she would leave the medications for resident #23 to take herself. Staff member O gave the example of this morning. She left four medications for resident #23 to take herself. Staff member O was going to go back and check if resident #23 took the medications. Staff member O stated she would give the rest to resident #23 to take if her breakfast tray was delivered. Staff member O stated she did not know the protocol for residents to be deemed safe to self-administer their own medications. Staff member O stated she went by her nursing judgement.</p> <p>During an interview on 10/24/24 at 10:34 a.m., staff member B stated the nurses were to complete the self-administration of medications assessment for residents and then alert the IDT team to review and make a determination. Staff member B stated there were not a lot of residents that self-administered their own medications at the facility compared to what had been observed.</p> <p>Review of resident #23's Self Administration of Medication assessment, dated 10/11/24, showed resident #23 did not pass the assessment, and the IDT did not review the results of the assessment.</p> <p>47752</p> <p>3. During an observation and interview on 10/22/24 at 9:18 a.m., resident #9 was sitting in a recliner in her room. Resident #9 had a bottle of artificial tears (eye drops) on her bedside table. Resident #9 stated she had dry eyes and used the eye drops when she needed. Resident #9 could not state how many times a day she used the artificial tears drops. Resident #9 stated she could not always open the bottle and would ask a staff member for help.</p> <p>During an observation on 10/22/24 at 9:25 a.m., resident #9 could not open the bottle of artificial tears eye drops.</p> <p>During an interview on 10/23/24 at 10:03 a.m., staff member I stated resident #9 could have medications at the bedside. Staff member I stated she would give resident #9 her ordered eye drops and was not aware of any eye drops in resident #9's room.</p> <p>During an interview on 10/24/24 at 7:50 a.m., staff member B stated we do not need a physician's order for self-administration of medications. A self-administration assessment was completed, and the IDT would recommend if the resident can self-administer medications or not. Staff member B stated, Our policy aligns with the regulations.</p> <p>Review of a facility assessment titled, Self-Administration of Medication, dated 10/20/24, showed:</p> <p>. 2. Capable of opening/closing medication containers - yes.</p> <p>Review of a facility document titled, Self-Administration of Medications, undated, showed:</p> <p>. 2. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident:</p> <p>. e. The resident has the physical capacity to open medication bottles .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>47752</p> <p>Based on observation, interview, and record review, the facility failed to ensure that oxygen use was accurately coded on a resident's MDS for 1(#10) of 37 sampled residents. Findings include:</p> <p>During an observation and interview with resident #10, on 10/22/24 at 8:59 a.m., the resident was sitting in her recliner. Resident #10 had an oxygen concentrator positioned next to the recliner, and the concentrator was set at 2 liters per minute. Resident #10 was wearing a nasal canula. Resident #10 stated she had been on oxygen for quite some time now, and she had to wear it (oxygen canula) all the time.</p> <p>During an observation on 10/23/24 at 11:45 a.m., resident #10 was sitting in her recliner and had on oxygen via nasal canula.</p> <p>Review of resident #10's Significant Change MDS, with an ARD of 8/30/24, showed Section O was blank under oxygen use.</p> <p>During an interview on 10/23/24 at 3:22 p.m., staff member B stated she was responsible for making sure the MDSs were accurate. Staff member B stated, I have started to identify issues with the MDS. I have noticed this is about the time when our MDS staff member was out. I have hired another MDS person to help. This should help with accuracy and timing. Ultimately it is my responsibility to make sure everything is accurate.</p> <p>Review of a facility document titled, Resident Assessments, undated, showed:</p> <p>. 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>47752</p> <p>Based on interview and record review, the facility failed to ensure the baseline care plan was completed with the staff member signature, title, date of completion, and a copy was given to the resident or resident representative, for 2 (#s 9 and 10) of 37 sampled residents. Findings include:</p> <p>1. During an interview on 10/22/24 at 9:18 a.m., resident #9 stated she had been at the facility since January 2024. Resident #9 had a BIMS score of 15. The BIMS score showed resident #9 was cognitively intact. Resident #9 stated she never received a copy of her care plan after admission.</p> <p>Review of resident #9's baseline care plan showed the document was completed with some information, but under Section 5, BCP Summary and Signatures, was not completed with the staff signature, title, date of completion, or resident/resident representative signature or date.</p> <p>2. During an interview on 10/22/24 at 8:59 a.m., resident #10 stated she had gone to the hospital but had returned to the facility in August 2024. Resident #10 had a BIMS score of 15. The BIMS score showed the resident was cognitively intact. Resident #10 stated she had never received a copy of any care plans (to include baseline).</p> <p>Review of resident #10's baseline care plan showed the document was completed with some information, but under Section 5, BCP Summary and Signatures, was not completed with the staff signature, title, date of completion, or resident/resident representative signature or date.</p> <p>During an interview on 10/23/24 at 11:37 a.m., staff member B stated care planning was currently an issue. Staff member B stated baseline care plans were to be done by the floor nurse upon admission. Staff member B stated, I just did a training with all the nurses and IDT on care planning last week, it is going to take some time (to improve).</p> <p>Review of a facility document titled, Care Plans-Baseline, undated, showed:</p> <p>. 4. The resident and/or representative are provided a written summary of the baseline care plan .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to develop a person-centered, comprehensive care plan for 6 (#s 9, 10, 32, 52, 53, and 100) of 37 sampled residents. Findings include:</p> <p>1. During an interview on 10/22/24 at 9:22 a.m., resident #9 stated she had constant pain, and some days were better than others.</p> <p>Review of resident #9's electronic medical record showed she had diagnoses of Fibromyalgia, Rheumatoid Arthritis, and Chronic Pain Syndrome.</p> <p>Review of resident #9's medication administration record, dated 8/1/24 - 10/24/24, showed resident #9 received oxycodone, 10 milligrams, every four hours, as needed for pain, and methadone, 10 milligrams, twice daily, for pain.</p> <p>Review of resident #9's comprehensive care plan showed no focus, goals, or interventions for pain, opioid pain medication, or non-pharmacological approaches.</p> <p>2. During an observation and interview, on 10/22/24 at 3:20 p.m., resident #10 was in her room sitting in a recliner. Resident #10 had on two liters of oxygen via nasal canula. Resident #10 stated she wore oxygen all the time.</p> <p>Review of resident #10's physician orders, dated 8/30/24-10/24/24, showed no physician's order for oxygen or details for the use of it.</p> <p>Review of resident #10's comprehensive care plan showed no focus, goals, or interventions for oxygen use.</p> <p>3. Review of resident #32's electronic medical record showed diagnoses of atrial fibrillation and heart failure.</p> <p>Review of resident #32's medication administration record showed the anticoagulant, Pradaxa, 150 milligrams, twice daily.</p> <p>Review of resident #32's comprehensive care plan showed no focus, goals, or interventions for the use of Pradaxa, an anticoagulant, or medication side effects.</p> <p>4. During an observation and interview on 10/22/24 at 9:12 a.m., resident #53 was sitting in his room in a recliner, looking at the wall. Resident #53 stated he was in the [NAME] Corps and was a helicopter pilot during the Vietnam War. Resident #53 stated there were times when being around a lot of people would upset him and caused him to have flash backs.</p> <p>Review of resident #53's comprehensive care plan showed no focus, goals, or interventions for PTSD or trauma.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/23/24 at 3:22 p.m., staff member B stated she was aware care plans were not comprehensive, or person centered. Staff member B stated she had recently done a training with the staff and IDT on care planning. Staff member B stated, It is a work in progress and is going to take some time. I have a newer IDT right now.</p> <p>47785</p> <p>5. Review of resident #52's physician orders showed, Oxygen at 2L per NC. Resident #52's care plan was not specific to the flow of oxygen. The care plan showed, OXYGEN SETTINGS via NC per provider orders.</p> <p>During an interview on 10/24/24 at 9:30 a.m., staff member A stated the night shift nurses would be responsible for updating the care plans, and staff member B would be responsible for reviewing them to ensure they were correct.</p> <p>6. Review of resident #100's electronic medical record showed an admitted [DATE]. All focus and interventions on the comprehensive care plan were labeled as CANCELLED. On the current care plan there were no focus or interventions. The care plan showed, No data found.</p> <p>During an interview on 10/23/24 at 3:33 p.m., staff member B stated, Someone is inadvertently closing the care plan when a resident is gone overnight instead of suspending it and putting it into review. That is why everything is cancelled. They have to start all over to recreate the comprehensive care plan. Staff member B was not aware this was occurring until the State Survey Agency requested these care plans.</p> <p>Review of a facility policy titled, Care Plans, Comprehensive Person-Centered, undated, showed:</p> <p>A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the needs of the resident's physical, psychosocial, and functional needs is developed and implemented for each resident .</p> <p>. 7. The comprehensive, person-centered care plan:</p> <p>a. Includes measurable time frames,</p> <p>b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47752</p> <p>Based on observation, interview, and record review, the facility failed to meet professional standards of practice by administering oxygen without a physician's order for 1(#10) of 37 sampled residents. Findings include:</p> <p>During an observation and interview on 10/22/24 at 8:59 a.m., resident #10 was in her room sitting in a recliner. Resident #10 had oxygen on at two liters via nasal canula. Resident #10 stated she had to wear oxygen at all times because of respiratory failure.</p> <p>During an interview on 10/23/24 at 3:22 p.m., staff member B stated physician's orders were needed for oxygen use, and the nursing staff were aware they needed physician's orders for oxygen use.</p> <p>During an interview on 10/24/24 at 9:02 a.m., staff member L stated physician's orders were needed for any treatment or medication, including oxygen.</p> <p>Review of resident #10's physician's orders, dated 8/30/24-10/24/24, showed no physician's order was placed for oxygen use.</p> <p>Review of a facility policy titled, Oxygen Administration, undated, showed:</p> <p>. Procedure:</p> <p>1. Verify physicians order. [sic]</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41952</p> <p>Based on observation, interview, and record review, the facility failed to coordinate a resident's care with hospice for 1 (#24) of 37 sampled residents. Findings include:</p> <p>During an observation and interview on 10/23/24 at 11:36 a.m., resident #24 stated she was so itchy, as she was actively scratching the right side of her body and her upper back. Resident #24 asked if hospice was there because they were the only ones who put the lotion on areas she could not reach. Resident #24 pulled up her gown and showed her gastric tube and explained the tube kept leaking and having issues, so she was placed on hospice.</p> <p>During an interview on 10/23/24 at 12:07 p.m., NF1 stated she was the hospice nurse visiting this week for resident #24. NF1 stated resident #24 was declining cognitively. NF1 stated resident #24 tended to scratch and needed a lot of lotion applied during her hospice visits or would accidentally pull her gastric tube because of her poor vision. NF1 stated hospice staff did not send their documentation or look at the facility documentation for the hospice residents. NF1 stated she would check in with a facility staff member when she came to the facility for any updates or changes for resident #24.</p> <p>During an interview on 10/24/24 at 9:12 a.m., staff member P stated the facility was just faxed a hospice plan of care for resident #24 the day before and assumed they were sent information from hospice monthly because they did not have any other information before then. Staff member P stated the hospice bath aide would come and the hospice nurses would visit weekly. The hospice nurses would check in with staff on the unit for resident #24 but did not leave any information unless it was an order change.</p> <p>During an interview on 10/24/24 at 10:20 a.m., staff member B stated her expectation for hospice was to send their notes after their visits. Staff member B stated they had gotten resident #24's hospice notes and plan of care the day before. Staff member B stated resident #24's hospice had been invited but did not come to the facility for her care plan meetings. For any needs, the facility called the main number for hospice or spoke with the hospice nurse when they were conducting their visit.</p> <p>Review of resident #24's care plan, last updated 8/15/24, showed resident #24 was on comfort measures. The care plan did not show she was on hospice or how care and services were provided between the facility and hospice.</p> <p>Review of resident #24's hospice admission packet showed she was admitted on to hospice on 9/17/24. The hospice admission packet showed the facility and hospice agency were to share care plans, care plan updates, and care conferences.</p> <p>Review of resident #24's electronic health record, on 10/22/24 and 10/23/24, only showed the hospice admission packet for 9/17/24. The hospice plan of care and visit notes were provided to the facility by hospice after the State Survey Agency requested the hospice information on 10/23/24.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47752</p> <p>Based on observation, interview, and record review, the facility failed to sufficiently assess residents for safe smoking, ensure residents were monitored while smoking, and allowed residents to keep smoking paraphernalia in their rooms, for 2 (#s 53 and 77) of 37 sampled residents. Findings include:</p> <p>1. During an observation and interview on 10/22/24 at 8:33 a.m., resident #53 was walking through the dining room and had his coat on. Resident #53 stated he was going outside to smoke and would be back shortly.</p> <p>During an observation and interview on 10/22/24 at 9:12 a.m., resident #53 was in his room sitting in a recliner. Resident #53 stated he had just gone outside to smoke his last cigarette because he was getting ready to have a procedure done soon. Resident #53 stated when he went outside to smoke, he had to leave the property. Resident #53 stated, It is quite the walk to get off the property. By the time I get there I am exhausted. Resident #53 stated he would go outside with resident #77 sometimes. Resident #53 stated staff did not monitor him or anyone else while smoking. Resident #53 stated he kept his lighter and cigarettes in the room with him, and usually put them in the top drawer of his bedside table, or in his coat pocket. Resident #53 stated he had never let anyone know when he was going outside to smoke, he just went outside whenever he wanted to.</p> <p>During an interview on 10/23/24 at 10:34 a.m., staff member I stated she did not think that resident #53 signed out to go outside and smoke. Staff member I could not locate any sign out sheets for resident #53.</p> <p>Review of resident #53's care plan, dated 1/20/24, showed:</p> <p>Focus: [Resident #53] is a smoker.</p> <p>Goals: [Resident #53] will not suffer injury from unsafe smoking practices.</p> <p>Interventions: Instruct [Resident #53] about smoking risks and hazards .</p> <p>- Instruct [Resident #53] on the facility smoking policy, locations and safety concerns</p> <p>- [Resident #53] can smoke unsupervised.</p> <p>Review of resident #53's physician's orders, from 1/1/24 - 10/24/24, showed no physician's order for the resident to smoke.</p> <p>Review of resident #53's electronic medical record, from 1/1/24-10/24/24, showed no smoking assessment had been completed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an observation on 10/21/24 at 1:47 p.m., resident #77 was in an electric wheelchair. The resident had on a coat, hat, light knit gloves, and a vest with high visibility markings. Resident #77 pushed the automatic door button and went outside. Once resident #77 was outside and on the sidewalk, she lit a cigarette as she wheeled herself down the sidewalk.</p> <p>During an observation and interview on 10/22/24 at 8:38 a.m., resident #77 was in her room sitting in a recliner. Resident #77 stated she was a smoker and would have to leave the property to smoke, and it was down the street quite a bit. Resident #77 stated her and resident #53 often went outside and smoked together. Resident #77 stated she had never had to sign out or let anyone know she was leaving the building. Resident #77 stated, If I want to go smoke, I just go. Resident #77 stated she kept her lighter and cigarettes in the room with her, but also kept an old bottle to put butts in.</p> <p>During an interview on 10/23/24 at 7:51 a.m., staff member A stated, This facility is a non-smoking facility. There is no policy, smoking assessments, or physician's orders for residents to smoke. Staff member A stated the residents were supposed to be signing out when they left the building.</p> <p>During an observation and interview on 10/23/24 at 2:30 p.m., resident #77 showed this surveyor where she went to smoke. The surveyor noted the area resident #77 went to was past the end of the block, and about 10 feet between the facility, and the hospital. Resident #77 stated that it is quite far from the building and was happy she had an electric wheelchair. Resident #77 pulled a small plastic bottle out of her coat pocket. The bottle was most of the way full of cigarette butts. Resident #77 stated she used the bottle, so she did not throw the butts on the ground. Resident #77 put the bottle back in her coat pocket and headed back to the facility.</p> <p>During an interview on 10/23/24 at 3:17 p.m., resident #77 stated staff member A just came and told her she had to sign out when she left the building and had offered her options to quit smoking.</p> <p>Review of resident #77's care plan, with a revision date of 7/2/24, showed:</p> <p>Focus: [Resident #77] is a smoker.</p> <p>Goals: [Resident #77] will not suffer injury from unsafe smoking practices.</p> <p>Interventions: Instruct [Resident #77] about smoking risks and hazards .</p> <ul style="list-style-type: none"> <li>- Instruct [Resident #77] on the facility smoking policy, locations and safety concerns</li> <li>- [Resident #77] can smoke unsupervised.</li> </ul> <p>A review of resident #77's physician orders, from 1/1/24 - 10/24/24, showed no physician order for resident #77 to smoke.</p> <p>A review of resident #77's electronic medical record, from 1/1/24 - 10/24/24, showed no smoking assessment had been completed.</p> <p>During an interview on 10/24/24 at 7:51 a.m., staff member A stated he was not sure what the facility would do if something happened to resident #s 53 and 77 if they were outside smoking. Staff member A stated, I just need to follow and enforce the no smoking rule for the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility document titled, Signing Residents out, with a revision date of August 2006, showed:</p> <ol style="list-style-type: none"> <li>1. Each resident leaving the premises (excluding transfers/discharges) must be signed out.</li> <li>2. A sign-out register is located at each nurses' station. Registers must indicate the resident's expected time of return.</li> <li>. 9. Residents must be signed in upon return to the facility.</li> </ol> <p>A request was made for the smoking policy, list of residents who smoke, smoking assessments, and physician's orders for smoking. The requested information was not received prior to the end of the survey.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>47752</p> <p>Based on observation, interview, and record review, the facility failed to weigh and document the weight in the resident's record, on intervals designed per the facility policy, after a readmission, for 1 (#10) of 37 sampled residents. Findings include:</p> <p>During an observation and interview on 10/22/24 at 8:59 a.m., resident #10 was in her room sitting in a recliner. Resident #10 stated she had been readmitted in August 2024 following a stay at the hospital. Resident #10 stated she did not have her weight checked very often and did not know how much she weighed. Resident #10 stated she would like to be weighed more frequently but had not asked staff to weigh her recently.</p> <p>During an interview on 10/23/24 at 10:34 a.m., staff member J stated weights were completed with showers at least monthly. Staff member J could not state when resident #10 was last weighed.</p> <p>Review of resident #10's recorded weights in the electronic medical record showed the only documented weight was on 9/1/24 at 2:50 p.m.</p> <p>Review of resident #10's care plan, with a revision date of 9/10/24, showed interventions under weight loss as, weigh at the same time of day and record: weekly.</p> <p>Review of a facility policy titled, Weight Assessment and Intervention, undated, showed:</p> <p>. 1. Residents are weighed upon admission and at intervals established by the interdisciplinary team.</p> <p>a. LTC weight to be obtained at time of admission than [sic] the following two days to establish a baseline weight. Then weekly x4 weeks then monthly .</p> <p>2. Weights are to be completed on the same day/time each week for consistency and documented in the individual's medical record.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41951</p> <p>Based on observation, interview, and record review, the facility failed to ensure provider orders were in place for the fluids to be administered during an enteral tube feeding and medication administration, for 1 (#361); and staff member R failed to ensure medications and enteral nutrition were administered in a timely manner, for 1 (#361) of 37 sampled residents. Findings include:</p> <p>During an observation on 10/22/24 at 10:53 a.m., staff member R verified the placement of resident #361's feeding tube. Staff member R opened the port, flushed the feeding tube with 60 ml of water, then closed the port. Staff member R added 30 ml of water to each cup of crushed medications, then stirred them to dissolve the medication. Staff member R administered the first of two medication cups with dissolved medications, then added 15 ml water to administer the rest of the dissolved medication residual in the cup. Staff member R then administered liquid potassium chloride 20 MEQ/15 ml, followed by 15 ml of water. Staff member R then administered crushed magnesium chloride 64 mg (dissolved partially in 30 ml of water). She added 15 ml of water to the undissolved portion of the magnesium and poured it into the feeding tube, followed by 30 ml (15 ml times two to administer the entire dose of magnesium), then a flush of 30 ml of water. Staff member R administered guaifenesin liquid 600 mg, followed by 15 ml of water. Staff member R then prepared the nutritional supplemental formula to be administered via the feeding tube.</p> <p>Review of resident #361's MAR for the scheduled AM 07 medications, on 10/24/24 at 9:05 a.m., showed:</p> <ul style="list-style-type: none"> <li>- Fluconazole Oral Tablet 100 MG . Give 100 mg via PEG-Tube one time a day ., Start Date 10/18/2024 0700,</li> <li>- hydroCHLOROthiazide Oral Tablet 25 MG . Give 25 mg by mouth in the morning ., Start Date 10/18/2024 0700,</li> <li>- Lisinopril Oral Tablet 40 MG . Give 40 mg via PEG-Tube one time a day ., Start Date 10/18/2024 0700,</li> <li>- Magnesium Chloride Oral Tablet 64 MG . Give 64 mg via PEG-Tube one time a day ., Start Date 10/18/2024 0700,</li> <li>- Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 100 MG . Give 100 mg by mouth in the morning ., Start Date 10/18/2024 0700,</li> <li>- Eliquis Oral Tablet 2.5 MG . Give 2.5 mg via PEG-Tube two times a day ., Start Date 10/17/2024 1900,</li> <li>- Potassium Chloride Oral Solution 20 MEQ/15ML . Give 20 mEq via PEG-Tube two times a day ., Start Date 10/17/2024 1900,</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- guaiFENesin Oral Liquid 100 MG/5ML . Give 600 mg via PEG-Tube four times a day ., Start Date 10/17/2024 1600, and</p> <p>- Enteral Feed Order four times a day Enteral: Enteral Nutrition via Pump (name of formula) at (375 cc) ml per hour for 4x per day via pump per (type) tube. If tube feeding is cycling/intermittent, Indicate start and stop times: Start infusion at scheduled time and continue for 1 hour, Start Date 10/18/2024 1900 . [sic]</p> <p>During an interview on 10/22/24 at 3:22 p.m., staff member R stated she would usually clarify provider orders regarding fluids during a tube feeding/medication administration, but there were no orders in place for resident #361. She stated she had just returned to work after days off. Staff member R stated she knew she was late administering her 7:00 a.m. medications and nutritional feeding to resident #361. She stated she usually would not call and notify the provider of late medication administration. Staff member R stated everything happened all at once in the morning and it put her behind on her schedule.</p> <p>During an interview on 10/22/24 at 3:25 p.m., staff member R stated during the tube feeding/medication administration for resident #361, she based the fluid administered on her knowledge. She stated she was taught to give between 15-20 ml of fluids between each cup of medication, then before and after the tube feeding. Staff member R stated she should have contacted the provider or dietician for a clarification order since there was not an order in place for the fluids during the tube feeding.</p> <p>During an interview on 10/22/24 at 4:30 p.m., staff member R stated she did give a 60 ml flush before resident #361's tube feeding this morning, without orders.</p> <p>During an interview on 10/24/24 at 10:17 a.m., staff member B stated physician orders should be in place for fluid administration during a tube feeding/medication administration. She stated if orders were not in place for fluid administration, a clarification with the provider would be requested.</p> <p>During an interview on 10/24/24 at 10:21 a.m., staff member B stated if the MAR had specific times listed for administration of the medications, then medications were to be administered one hour before or one hour after, per the facility's policy.</p> <p>Review of resident #361's medication administration record, on 10/24/24 at 9:05 a.m., showed:</p> <ul style="list-style-type: none"> <li>- Enteral Feed Order four times a day for Tube feed Enteral:</li> <li>- Flush feeding tube with 30 cc of water before and after medication and bolus administration.</li> <li>- Start Date 10/22/2024 1900 (7:00 p.m.).</li> </ul> <p>Resident #361 was admitted to the facility on [DATE]. No orders for the flush with water of the tube feeding, four times a day, were in place until 10/22/24 at 7:00 p.m., five days after her admission. Staff member R had administered medications and an enteral nutritional feeding four hours after the scheduled medication and enteral tube feeding administration times. The next scheduled enteral tube feeding, and medication administration time was less than 2 hours, when it was originally scheduled for 6 hours in between administration times. No provider notification was completed for clarification or adjustment of the next times of administration for the enteral feeding or medication.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47752</b></p> <p>Based on observation, interview, and record review, the facility failed to identify and address PTSD, provide trauma-informed care, and meet professional standards that accounted for the resident's experiences and preferences to manage and prevent or minimize PTSD triggers, for 1 (#53) of 37 sampled residents. Findings include:</p> <p>During an observation and interview on 10/22/24 at 9:12 a.m., resident #53 was sitting in his room in a recliner, looking at the wall. Resident #53 stated he was in the [NAME] Corps and was a helicopter pilot during the Vietnam War. Resident #53 stated there were times when being around a lot of people upset him and caused him to have flash backs.</p> <p>During an observation and interview on 10/23/24 at 8:22 a.m., resident #53 was sitting in his room. Resident #53 stated he had just finished his breakfast in the dining room. Resident #53 stated, I ate in the dining room today, I felt it would not be too overwhelming. There are times when I eat in my room because there are just too many people in the dining room. Resident #53 stated, I have a history of PTSD and know what triggers me and how to deal with it. If I feel like there is going to be an issue, I just stay in my room and away from everyone. Resident #53 stated he had never been asked about his PTSD or experiences by facility staff. Resident #53 became tearful during the interview.</p> <p>During an interview on 10/24/24 at 8:12 a.m., staff member F stated a trauma assessment was completed with residents upon admission and reviewed on an annual basis. Staff member F stated she could not find the trauma assessment for resident #53 and was not aware the resident had PTSD.</p> <p>During an interview on 10/23/24 at 10:34 a.m., staff members I and L stated they worked with resident #53. Staff members I and L stated they were not aware of any residents having PTSD. Staff members I and L stated they were trained annually on PTSD and trauma care online.</p> <p>During an interview on 10/24/24 at 9:16 a.m., staff member E stated in October 2023 the facility had implemented a PTSD screening on admission and it was reviewed yearly. Staff member E stated there was not a trauma assessment done on resident #53. Staff member E stated, We missed him, I am not sure why.</p> <p>Review of a facility policy titled, Trauma-Informed and Culturally Competent Care, undated, showed:</p> <ul style="list-style-type: none"> <li>. To address the needs of trauma survivors by minimizing and/or re-traumatization.</li> <li>. Resident Screening <ul style="list-style-type: none"> <li>1. Perform universal screening of residents . Utilize screening tools and methods that are facility approved, competently delivered, culturally relevant and sensitive.</li> </ul> </li> <li>. Resident Assessment <ul style="list-style-type: none"> <li>1. Assessment involves in-depth process of evaluating the presence of symptoms,their relationship to trauma, as well as identification of triggers . [sic]</li> </ul> </li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41951</p> <p>Based on observation, interview, and record review, the facility:</p> <ul style="list-style-type: none"> <li>- failed to ensure an enhanced barrier precautions door sign was posted to notify all staff of the infection control precautions, and have gowns readily available for use during a tube feeding, for 1 (#361);</li> <li>- failed to ensure staff member R adhered to standard precautions during medication administration via a tube feeding, by placing medications to be administered on an unclean surface without a protective barrier in place, for 1 (#361);</li> <li>- failed to ensure staff member S and Q adhered to proper infection prevention practices related to hand hygiene during donning and doffing of gloves, for 2 (#s 42 and 370);</li> <li>- failed to ensure staff members G and K adhered to proper hand hygiene prior to entering and exiting resident rooms, for 6 (#s 29, 68, 70, 73, 77, and 88) of 37 sampled residents; and,</li> <li>- failed to ensure staff member C was performing infection tracking, surveillance, and ensuring staff member H maintained infection control practices while transporting laundry.</li> </ul> <p>Findings include:</p> <p>1. During an observation on 10/22/24 at 10:45 a.m., inside the door of resident #361's room, was an enhanced barrier precautions cart, with the precautions sign on the top of the cart. During the administration of medications and tube feeding, staff member R wore gloves, but was not wearing a gown, a mask, or any type of eye/face protection shield. Resident #361 had coughed several times during the medication administration via the feeding tube. Upon exit of resident #361's room, no enhanced barrier precautions sign was on the door.</p> <p>During an interview on 10/22/24 at 4:30 p.m., staff member R stated she believed resident #361 should be on enhanced barrier precautions due to her coughing during the tube feeding. She stated there were not any masks/shields or gowns in the precautions cart inside resident #361's room or precautions sign on the door.</p> <p>Review of resident #361's electronic health record document, titled, Order Summary, on 10/22/24 at 4:42 p. m., showed:</p> <ul style="list-style-type: none"> <li>- . EBP - Enhanced Barrier Precautions d/t peg tube.</li> <li>- . Active 10/17/2024.</li> </ul> <p>Review of the facility policy titled, Infection Control Plan, Enhanced Barrier Precautions, undated, showed:</p> <ul style="list-style-type: none"> <li>- .EBP are indicated for residents with any of the following:</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- . Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.</p> <p>2. During an observation on 10/22/24 at 10:45 a.m., staff member R prepared to administer medications to resident #361 via a feeding tube. Staff member R placed the medication cups down on resident #361's bedside table, without wiping/cleaning the table, and the table was visibly dirty with spilled, dried residue. Staff member R moved some of resident #361's personal items off the bedside table, placed a protective barrier on the table, then moved the medication cups from the unclean surface, onto the barrier.</p> <p>During an interview on 10/22/24 at 4:25 p.m., staff member R stated she was unable to find a table specifically for the tube feedings of resident #361. Staff member R stated for resident #361's tube feeding/medication administration, she moved items off the resident's bedside table, laid down the barrier, but had already placed the medications down onto the uncleaned tabletop. She stated she should have prepared the table, cleaned it, set down the barrier, then retrieved the medications, after the barrier was already on the table.</p> <p>3. During an observation on 10/23/24 at 8:43 a.m., staff member Q administered resident #370's oral medications to him in his room. Resident #370 also had an injection of enoxaparin 30 mg scheduled at this time. Staff member Q donned clean gloves, gave resident #370 his injection, then removed and disposed of the gloves. Staff member Q exited resident #370's room, walked to the dining room, poured juice into a cup with polyethylene glycol 17 grams, and stirred to dissolve the powder. Staff member Q returned to resident #370 and administered the polyethylene glycol/juice mixture.</p> <p>Staff member Q did not sanitize or wash her hands prior to donning clean gloves for the enoxaparin injection. Staff member Q did not sanitize or wash her hands after doffing the gloves or when she exited resident #370's room.</p> <p>During an interview on 10/23/24 at 8:51 a.m., staff member Q stated staff should sanitize their hands before putting gloves on and after taking gloves off. She stated staff should sanitize their hands before entering a resident's room and when leaving the same room. Staff member Q stated she did not sanitize her hands when she took her gloves off in resident #370's room or when she exited his room.</p> <p>4. During an observation on 10/23/24 at 9:10 a.m., staff member S prepared to give resident #42 her eye drops in her room. Staff member S donned clean gloves, administered resident #42's eye drops, doffed her gloves, then sanitized her hands.</p> <p>Staff member S did not sanitize or wash her hands prior to donning clean gloves.</p> <p>During an interview on 10/23/24 at 9:13 a.m., staff member S stated she should have sanitized her hands prior to donning the clean gloves in resident #42's room. She stated hands should be sanitized before putting gloves on and after removing gloves.</p> <p>Review of the facility policy titled, Infection Control Plan, Standard Precautions, undated, showed:</p> <p>- . A. Hand Hygeine [sic]</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- . e. when entering and leaving a resident's room or apartment, and</p> <p>- f. after removing personal protective equipment (e.g., gloves, gown, facemask).</p> <p>47752</p> <p>5. During an observation and interview, on 10/22/24 at 8:55 a.m., staff member G was passing drinks to some residents. Staff member G knocked on resident #73's room and went in. Staff member G exited resident #73's room, grabbed the drink cart, picked up a coffee cup and poured coffee. Staff member G entered resident #73's room, placed the coffee cup on the bedside table and exited the room. No hand hygiene was performed prior to entering or exiting resident #73's room. Staff member G pushed the drink cart in front of resident #70's room, knocked on the door and entered the room. Staff member G came out of resident #70's room, touched the drink cart, picked up a cup, took the lid off the milk and poured it into the cup. Staff member G then went back into resident #70's room, placed the cup of milk on the bedside table and exited the room. No hand hygiene was performed prior to entering or exiting resident #70's room. Staff member G pushed the drink cart to resident #88's room, knocked on the door and entered the room. Staff member G exited resident #88's room and poured a glass of orange juice. Staff member G took the glass of orange juice into resident #88's room and gave the resident the glass. No hand hygiene was performed prior to entering or exiting resident #88's room. Staff member G stated, I should have either washed my hands or used sanitizer, I just didn't. I know that I am supposed to do it before and after I leave a resident's room. I have been educated on hand hygiene.</p> <p>During an observation and interview on 10/23/24 at 10:17 a.m., staff member K entered resident #77's room and took the lunch and dinner order. Staff member K exited the room. No hand hygiene was completed prior to entering or exiting the room. Staff member K walked down the hall pushing a cart and stopped at resident #29's room. Staff member K entered resident #29's room, took her lunch and dinner order and exited the room. No hand hygiene was completed prior to entering or exiting resident #29's room. Staff member K pushed a cart down the hall and stopped at resident #68's room. Staff member K entered resident #68's room, took his lunch and dinner order, and exited the room. No hand hygiene was completed prior to entering or exiting resident #68's room. Staff member K stated she knew the facility policy on hand hygiene and should have completed hand hygiene prior to entering and exiting resident rooms. Staff member K stated she had been educated on proper hand hygiene.</p> <p>6. During an observation and interview on 10/22/24 at 10:33 a.m., staff member H had a cart in the hallway with clean clothes. The cart did not have a cover over the clothing. Staff member H stated clean clothes were supposed to be covered while being transported.</p> <p>Review of the document titled, Infection Prevention and Control Program, undated, showed no information related to clean linen procedures or distribution of clean linen.</p> <p>Review of a facility document titled, Main Laundry Procedure, undated, showed no information related to the clean linen procedures or distribution of clean linen.</p> <p>7. During an interview on 10/24/24 at 8:25 a.m., staff member C stated she had done multiple hand hygiene trainings and audits with the staff. Staff member C stated she was responsible for the infection control program. Staff member C stated she had no documentation, or tracking and trending for infection surveillance at this time. Staff member C stated she needed to start documenting better.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Immanuel Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of a facility document titled, Infection Prevention and Control Program, undated, showed:</p> <p>Purpose: Provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. The infection prevention and control program will include elements for preventing, identifying, reporting, and controlling infections and communicable diseases.</p> <p>. B. Infection Control Nurse is responsible for</p> <p>1. On-going monitoring of infections .,</p> <p>. g. tracking resident infections .</p>