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	12/31/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure kitchen personnel had a process in place for documentation of weekly deep cleaning of the ovens; and failed to ensure areas surrounding the fryer and griddle were cleaned daily (end of shift). These deficient practices had the potential to increase the risk of foodborne illnesses for anyone receiving food, or having food prepared, from the facility kitchen. Findings include:1. Kitchen OvensDuring an observation and interview on 12/30/25 at 2:17 p.m., staff member C stated the ovens in the kitchen had been cleaned about a month ago. Staff member C opened the oven furthest away from the flat top griddle. The oven had dark brown, burnt food, and grease splatter covering both doors, burnt food chunks below the doors, and baked on grease splatter on all sides of the oven. Staff member C opened the oven closest to the flat top griddle, which also had the same baked on, burnt food, and grease splatter on both doors, all sides of the oven, and burnt food chunks below the doors. Staff member C stated she did not have any documentation of cleaning logs for the ovens. Staff member C stated the kitchen staff were always cleaning, and she trusted her employees to clean the equipment.During an interview on 12/30/25 at 2:25 p.m., staff member D stated he had not cleaned the ovens for over a month.Review of the facility's policy and procedure titled, Line Equipment Cleaning Policy & Procedure, undated, showed:- . Weekly Deep Cleaning- . Deep clean ovens . 2. Flat Top Griddle and FryerDuring on observation and interview on 12/30/25 at 2:25 p.m., the flat top griddle had a hole, at the front of the griddle, where excess grease and fried food particles were scraped from the top of the griddle throughout the day. Underneath the griddle and the hole, was a grease trap. Staff member D stated the grease trap was emptied daily. The hole in the flat top griddle was caked with layers of sticky, dried grease and food particles, which had accumulated over a period of time. Staff member D stated the hole in the griddle was not cleaned routinely when the grease trap was emptied. During an observation and interview on 12/30/25 at 2:39 p.m., on the walls surrounding the fryer was liquefied and dried accumulated grease. On the floor next to the fryer was black, dried grease around the wheels and on the floor tile. On the floor next to the fryer was liquefied grease on the tile and surrounding the wheels. Staff member C stated the area around the fryer was cleaned daily.During an observation and interview on 12/31/25 at 7:16 a.m., a food cart was placed on the left side of the fryer. When the food cart was moved, liquid, light brown grease was all down the left side of the fryer, on the floor, and around the wheels. Dark brown, congealed grease was caked on the wheels and the floor surrounding the wheels of the fryer. Staff member C stated she would get the area cleaned.Review of the facility's policy and procedure titled, Line Equipment Cleaning Policy & Procedure, undated, showed:- . Daily Cleaning (End of Shift)- Remove food debris and grease from all equipment,- . Wipe interior and exterior surfaces with approved cleaners,- . Sweep and mop floors under and around line equipment,- . Weekly Deep Cleaning- Degrease and polish flat top griddle and drain system, and- . Pull equipment when possible to clean floors and walls. [sic]

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, staff member E failed to uphold infection control precautions for 1 (#29) resident, to include failing to use enhanced barrier precautions (EBP) while performing the treatment to an open skin tear for a resident with a known MDRO; placing wound care supplies onto an unclean surface during wound care; and failing to perform hand hygiene before entering a resident's room and donning clean gloves; failed to ensure staff member J followed EBP while administering medications in a gastrostomy tube for 1 (#66) out of 23 sampled residents. The facility also failed to ensure cleaning and a cleaning log was completed for a CoaguChek XS System for 1 (#10) of 1 resident utilizing the CoaguChek XS System. These deficient practices had the potential to increase the risk of communicable diseases within the facility. Findings include: 1. During an observation and interview on 12/30/25 at 9:39 a.m., resident #29 was holding a blood-soaked tissue on his left forearm. Resident #29 stated he had removed the sock fabric protector from his left forearm, and when he pulled the sock off, it removed the scab on his forearm, causing it to bleed. Staff member E entered resident #29's room and laid wound care supplies (unpackaged roll of gauze, scissors, and tape) down onto a pile of magazines, on top of a dresser. Staff member E donned clean gloves to begin care of resident #29's left forearm, to the open skin tear. Staff member E did not sanitize her hands before entering the room or before donning clean gloves; she did not don an isolation gown, and she did not put down a clean barrier when wound care supplies were placed onto the magazines. Staff member E needed additional supplies to cover resident #29's skin tear, so she doffed her gloves, retrieved her supplies, and left the room. Inside resident #29's room, next to the door, was a personal protective equipment (PPE) container with drawers holding isolation gowns. On top of the PPE container was a basket with various clothing items and a gait belt. Underneath the basket was an enhanced barrier precautions sign (which was visually blocked by the basket), which showed the appropriate PPE to be worn during high-contact resident care. During an observation on 12/30/25 at 9:44 a.m., staff member E entered resident #29's room and laid wound care supplies onto a pile of magazines, on top of a dresser. Staff member E did not put down a clean barrier on the unclean surface. Staff member E performed hand hygiene and donned clean gloves. Staff member E cleaned, applied antibiotic ointment, and dressed resident #29's skin tear. Staff member E did not wear an isolation gown during this high-contact resident care. Review of resident #29's electronic health record showed he was admitted to the facility on [DATE]. Resident #29's admitting diagnoses included, but was not limited to: - Infection following a procedure, other surgical site, subsequent encounter, - Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, subsequent encounter, - Methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, and - Other bacterial infections of unspecified site. During an interview on 12/30/25 at 9:53 a.m., staff member E stated resident #29 no longer had a PICC line (percutaneous indwelling central catheter) to deliver antibiotics, and she did not believe he (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was on any type of isolation precautions. Staff member E stated she should have placed a clean barrier under the bandages or wound care supplies; she just did not want to put the supplies on resident #29's bedside table. Staff member E stated she had completed hand hygiene training and should sanitize her hands before entering a room and before donning clean gloves. Staff member E stated she missed performing hand sanitization the first time she entered resident #29's room. Staff member E stated the CNA for resident #29 had told her he was bleeding profusely and she was trying to hurry. During an interview on 12/31/25 at 9:30 a.m., staff member B stated a resident with a diagnosis of a multi-drug resistant organism would be placed on enhanced barrier precautions (EBP), whether they had a wound or an indwelling device. Staff member B stated staff would know if a resident was on EBP because a PPE cart would be placed inside of the resident's room. Staff member B stated some families had requested the EBP sign not be placed on the outside of their family member's room, for privacy purposes. Staff member B stated annual employee infection control competencies had been performed in October of 2025, which included hand hygiene and donning/doffing of PPE. Staff member B stated any direct care staff should sanitize their hands before donning gloves. Staff member B stated a nurse would be routinely expected to put down a clean barrier before placing wound care supplies onto a surface. 2. During an observation on 12/30/25 at 8:24 a.m., resident #66 had a continuous tube feed running but did not have an EBP sign on the outside of his door for any isolation precautions. Review of resident #66's physician order showed: EBP – Enhanced Barrier Precautions d/t G-Tube, every shift for infection prevention. During an observation and interview on 12/31/25 at 8:44 a.m., staff member J administered the medications (amlodipine besylate, aspirin, clopidogrel bisulfate, lansoprazole, senna, and docusate sodium) for resident #66's G-tube with donned gloves but never used an isolation gown to ensure the employee was following the EBP guidelines. Resident #66's door had an EBP sign on the door as of 12/31/25 (not before that). Staff member J stated they felt EBP was unnecessary to wear, because nurses in the hospital were not required to wear EBP during any G-tube feedings or medication administration. Staff member J stated they were open to more education on why EBP was needed in a nursing home environment versus a hospital environment. Review of the facility's policy titled, Enhanced Barrier Precautions, last revised 12/24, showed: - Policy Statement - Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. - . 2. Enhanced barrier precautions apply when: - a. A resident is infected or colonized with a CDC-targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained, - . 4. Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- . 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply, - a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room), - 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: - . j. wound care (any skin opening requiring a dressing). [sic] Review of the facility's document titled, Infection Prevention and Control Plan, undated, showed: - . Standard Precautions - . A. Hand Hygiene - 1. Staff must perform hand hygiene (even if gloves are used) - . a. before and after contact with the resident, and - . e. when entering and leaving a resident's room or apartment. 3. During an interview on 12/30/25 at 9:35 a.m., resident #10 stated the facility had been obtaining her INR levels, but the results were sometimes different from the hospital's INR lab result that was obtained on the same day. Resident #10 stated she felt the facility might need to recalibrate the CoaguChek XS System or she felt there might have been something wrong. During an interview and observation on 12/31/25 at 9:25 a.m., staff member K stated the facility did not have a cleaning log for the CoaguChek XS System and the facility had the machine for about a year now. Staff member K used her thumb to pop the plastic lid off the machine to expose the meter test strip guide, and there were two very small, uncleaned areas with a slightly greenish-blue substance. A request was made for the Coagucheck cleanings, but no supporting documentation was provided by the facility by the end of the survey. Review of a facility document titled, Coaguchek XS System Policies & Procedures Manual, no date, showed: - . Cleaning/disinfecting the meter test strip guide . Use only 70% isopropyl alcohol or 10% bleach solution . -Debris on the test strip guide can cause problems with results. Clean the meter as recommended in the CoaguChek XS System User Manual .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to identify and implement a care plan for concerns related to a resident's diagnosis of Post Traumatic Stress Disorder (PTSD), and or the triggers for the PTSD, for the provision of trauma-informed care, for 1 (#111) of 23 sampled residents. Findings include:A review of resident #111's diagnoses list in the EMR showed Post-traumatic stress disorder, unspecified, with a date of 7/14/2025.A review of a facility document titled, Trauma Informed Care Assessment-PTSD 5, with an effective date of 11/24/24, for resident #111, showed: PTSD SCREENREAD. Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide.1. Have you ever experienced this kind of event? . The yes box was checked.A review of resident #111's comprehensive care plan failed to show that he had PTSD or any interventions for PTSD.During an interview on 12/31/25 at 10:11 a.m., staff member G stated social services would revise a resident's care plan based on the MDS and the resident's diagnosis of PTSD.During an interview on 12/31/25 at 10:11 a.m., staff member I stated PTSD should have been care planned for resident #111. His PTSD triggers should have been identified, and care planned, even if they were not triggering him. A review of a facility policy titled, Trauma-Informed and Culturally Competent Care, with a revised date of August 2022, showed: PurposeTo guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice.To address the needs of trauma survivors by minimizing triggers and/or re-traumatization.Definition.'Trauma' results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.'Trauma-informed care' is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.'Trigger' is a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening.Resident Care Planning1. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate.2. Identify and decrease exposure to triggers that may re-traumatize the resident.3. Recognize the relationship between past trauma and current health concerns (e.g., substance abuse, eating disorders, anxiety and depression). [sic]

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, facility nursing staff failed to document blood pressure readings before administering a blood pressure medication with provider orders to hold the medication, if the resident's blood pressure was under 110/60 mmHg, for 1 (#95) of 23 sampled residents. This deficient practice had the potential to cause the resident to become hypotensive. Findings include:A review of a provider order in resident #95's EHR, dated 9/5/25, and ordered by staff member F, showed: Medication: Labetalol HCL Oral Tablet 100 mg, **DAW** Give 50 mg by mouth in the morning for hypertension Hold for pressure below 110/60. [sic]A review of another provider order in resident #95's EHR, dated 9/5/25, and ordered by staff member F, showed: Medication: Labetalol HCL Oral Tablet, Give 25 mg by mouth at bedtime for HTN Hold for pressure below 110/60. [sic]A review of resident #95's blood pressure recordings in her EHR, showed 152 blood pressure readings were not recorded from 10/2/25 through 12/25/25. Resident #95 should have had two blood pressure readings recorded each day from 9/5/25. A review of resident #95's medication administration record, for the dates of 10/1/25 through 12/29/25, showed the morning and evening dose of Labetalol had been administered on all but seven encounters. During an interview on 12/31/25 at 9:29 a.m., staff member B stated if the medication order had parameters for administration, the vitals should have been taken on the resident and entered in the EMR, before the administration of the blood pressure medications.A review of a facility policy titled, Administering Medications, with a revised date of April 2019, showed: . 10. The following information is checked/verified for each resident prior to administering medications:a. Allergies to medications; andb. Vital signs, if necessary.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure pain medications were offered or given prior to ambulation, and non-pharmacological pain interventions were present and used for 1 (#112) of 23 sampled residents, and the resident stated her pain would sometimes make her cry. Findings include:During an observation and interview on 12/29/25 at 4:07 p.m., resident #112 stated she was having terrible pain in her hands. She stated she had arthritis and staff members would make her do exercises even though she was having immense pain. She stated she had gotten up with staff twice today and both times she experienced pain. She also stated staff members would haul you out of bed at 5:00 a.m. sometimes, which she stated she did not prefer. She explained while staff members took her to the dining room, she had to grab a bar while standing and she winced while explaining the process with her hands. She stated the CNAs would sometimes tell the nurse that she needed an aspirin, but resident #112 stated the communication did not always happen. Resident #112 did not have any ice, heat, or any other forms of non-pharmacological pain interventions present at her bedside or on her hands. Observation of resident #112's hands showed large visible deformities and bony bumps on her knuckles. Resident #112 showed difficulty grabbing objects.During an interview on 12/30/25 at 8:03 a.m., resident #112 stated her hands felt miserable.During an interview on 12/30/25 at 8:30 a.m., resident #112 stated she would usually cry from the pain when ambulating but stated today she did not feel that bad concerning her level of pain.During an interview on 12/31/25 at 8:25 a.m., staff member L stated resident #112 would complain of her hands hurting quite often, but stated resident #112 was able to complete all of the necessary ADLs during the day.During an interview on 12/31/25 at 8:44 a.m., staff member J stated they were unsure how frequently resident #112 complained of pain. Staff member J stated resident #112 seemed to sleep at night with no concerns of pain but would show signs of pain when ambulating specifically. Staff member J stated staff members did not give resident #112 pain medication prior to ambulation and this was not in the care plan. Staff member J stated resident #112 did not have a lot of non-pharmacological interventions for the pain in her hands. Staff member J stated heat could be a helpful option for someone with arthritis, but the floor staff were unable to apply heat unless it was permitted by the DON. Staff member J also stated ice could be helpful for inflammation, anti-inflammatory medications, or movement could help resident #112's pain as well.Review of resident #112's physician order showed: AROM to lower extremities ankle, knee, hip active range of movement in bed and chair. Refer to handout provided in room with AROM exercises every day shift.Review of resident #112's Care Plan, with an initiation date of 11/20/25, showed: Anticipate (resident #112)'s need for pain relief and respond immediately to any complaint of pain. Resident #112's Care Plan showed pain interventions but failed to show pain medication offered prior to ambulation and non-pharmacological pain interventions such as range of motion, heat, ice, etc.