STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275132	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitefish Care and Rehabilitation	1305 E 7th St Whitefish, MT 59937

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure residents felt respected and cared for due to concerns with staffing customer service approach for 9 (#s 1, 5, 6, 8, 9, 10, 11, 12, and 15) of 12 sampled residents. This deficient practice resulted in residents feeling: disrespected, not properly cared for, and that their needs were not all met. Findings include:During an interview and observation on 12/3/25 at 8:00 a.m., resident #9 stated he did not have his teeth brushed yet for the morning. He stated, They're (staff) always busy too. They can't just help one person (at a time). Resident #9 stated the staff members often would come to his room to respond to a call light, take care of one need, but then would get called to another room without taking care of all the requested needs. He stated staff members would rarely offer to brush his teeth or wash his face in the morning, and some staff members would make him feel like he was bothering them if he asked for too much.During an interview on 12/3/25 at 8:58 a.m., resident #10 stated some of the staff members at the facility were mean to her.During an interview with resident #11 and #12 on 12/3/25 at 9:55 a.m., resident #11 stated, This place is rotten. The way you're treated. Resident #12 stated, They (staff members) mock you. Resident #11 stated she saw staff members mock another resident one time while they were walking in the hallway. Resident #11 stated, They (staff) act like this is a game. Resident #11 stated that many of the staff members were lacking in customer service approach, as her previous roommate was on hospice and had been crying out in pain one night. Resident #11 stated the CNA who was there that day was cussing at her roommate while they were doing cares. Resident #12 stated, (There are) Several (staff members) that just have that attitude. And there is one that is a loudmouth. Resident #11 stated that many of the staff members make residents feel like they are doing them a favor. Resident #11 stated the staff members do not seem to do the basic things that make you feel special.During an observation on 12/3/25 at 12:13 p.m., the surveyor walked into the dining room and heard staff member J laugh and state, Oh shit. Staff member J along with four other staff members continued to laugh a bit while passing out the trays in the dining room.During an interview on 12/3/25 at 1:26 p.m., NF1 stated, They (staff members) are not invested in these residents and it is obvious to me. NF1 stated a CNA had said to NF1 and resident #5 one time Well he already shit once today. She said they do not move resident #5 out of his wheelchair except to change his brief or to go to bed at night. NF1 stated resident #5's legs swell up because of this. NF1 stated that, overall, the staff members lack caring mannerisms, education, and communication in the whole building. NF1 stated, I've been more stressed with him there than when he was here (at home).During an interview on 12/3/25 at 4:21 p.m. with residents #6 and #1, resident #1 stated a good majority of the staff have an attitude and the travelers are bad. Resident #1 stated, They just don't care. Resident #6 stated, (The staff members have) no work ethic and just attitude. Resident #1 stated that many residents in the facility had little confidence in the grievance process and the staff members. Resident #6 stated, Eventually you give up, and We just have to suffer through the attitude. Resident #6 stated that many of the residents did not speak up about their concerns due to the concern for fear of getting kicked out of the facility, with nowhere to go or no family support.Review of the Facility's Grievances regarding concerns of staff customer service from 7/1/25 to 12/1/25 included: -7/17/25 - Resident #11 wrote: Additude. She passes dirty looks around like they are a gift, [sic]-9/17/25 - Staff member K wrote: (Resident #8) did not want her chicken sandwich for lunch and asked for a PB and J (peanut butter and jelly sandwich) in sub (substitution). Kitchen staff refused . Not offering to make it after trays were passed.,-11/12/25 - Resident #15 wrote: Resident expressed concern surrounding staff approach to patient cares, felt cares were lacking in customer service approach,-11/21/25 - Resident #11's grievance showed: (Resident #11) stated that a colored girl (staff name) is very loud at night and saying things to roommate like so sorry you have been with a grump. Also said to (resident #11) while kneeling, You white people think this is where we should be like this .,-12/1/25 - Resident #1's grievance showed: Resident used urinal and told CNAs that he was wet, they walked away without changing him or coming back with clean dry linen.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure a clean room for 3 (#s 5, 7, and 9) of 12 sampled residents. Findings include:a. During an observation on 12/2/25 at 2:33 p.m., resident #5's floor was dirty with visible dirt near the area right by the bed. There were little pieces of paper underneath resident #5's bed.During an interview on 12/3/25 at 1:26 p.m., NF1 stated there was garbage on the floor constantly in resident #5's room. NF1 stated they have never seen a staff member clean underneath the beds and stated they find garbage located there.b. During an observation and interview on 12/2/25 at 3:22 p.m., resident #7's floor had visible dirt where the resident and the wheelchair was located. Resident #7 stated, They could do a better job (with cleaning). Resident #7 stated the cleaning depended on the person and stated he often went outside and would drag dirt in so he felt bad for the cleaners and would never complain.During an interview on 12/3/25 at 5:40 p.m., staff member L stated some staff members were better at cleaning than others. They stated they would only clean something if it was needed and document it. c. During an observation on 12/3/25 at 8:00 a.m., resident #9 had two oxygen tubing ear protectors and a green piece of garbage located underneath his bed.During an observation on 12/4/25 at 8:15 a.m., resident #9's bed had two oxygen tubing ear protectors and a green piece of paper located underneath his bed. Review of a facility document, no title, dated 12/2/25 and 12/3/25, showed: resident #5 and resident #7's room was cleaned with a dry mop and wet mop on 12/3/25, but no records were shown for these residents on 12/2/25. The documentation was requested, and not received. Resident #9 had his room cleaned by a dry and wet mop on 12/3/25.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure scheduled showers were consistently completed and documented for 4 (#s 1, 5, 6, 7) residents of 12 sampled residents. Findings include:1. During an interview on 12/3/25 at 1:26 p.m., NF1 stated the staff members did not take care of resident #5's overall hygienic needs including showering, shaving, hair trimming, and fingernail clipping frequently enough which resulted in NF1 doing these cares. NF1 stated resident #5 would refuse a shower sometimes and stated resident #5 refused a shower yesterday (12/2/25).Review of the [Facility Name] Shower Schedule, no date, showed resident #5 had showers scheduled for Tuesdays and Fridays.Review of resident #5's EHR showed nursing notes regarding showers from 11/11/25 to 12/2/25:-11/11/25 (Tuesday), a shower was documented, -11/19/25 (Wednesday), a shower was documented. Eight days later,-11/25/25 (Tuesday), a shower was documented. Six days later,-12/2/25 (Tuesday) no documentation of a given or refused shower. Documentation showed resident #5 did not receive a shower and was potentially not offered a shower for seven days.2. Review of the [Facility Name] Shower Schedule, no date, showed resident #7 had showers scheduled for Sundays and Thursdays.Review of resident #7's EHR showed one documentation of a shower refusal on 9/30/25. No other documentation of any showers completed or refused was documented in the EHR since his admission on [DATE].During an interview on 12/4/25 at 10:06 a.m., staff member C stated resident #7 showered independent with minimal assistance.During an interview on 12/4/25 at 11:01 a.m., staff member B stated it was the facility's policy to document on paper only. Staff member B stated the facility had problems in the past with documented showers.Review of many paper charting shower sheets of resident #7's showed: inconsistencies in regularly scheduled shower dates (12/2/25 (Tuesday); 11/25/25 (Tuesday); 11/21/25 (Friday)).3. During an interview with residents #6 and #1 on 12/3/25 at 4:21 p.m., resident #6 stated getting the scheduled showers were a concern. Resident #6 pointed to his roommate (resident #1) and stated resident #1 went two months without getting a shower. Resident #6 stated he kept a record of all of the incidents that happened to him and on November 10th he was left in the shower room for 45 minutes. Resident #6 stated there was no pull cord for him in the shower room and he was wheelchair bound. Please see F689 for further details regarding safety in the shower. Resident #1 stated showers were important to him because he was a big guy and sweat was an issue. Resident #1 also stated the facility did not always get the correct size of a fitted bed sheet so the sheet would move leaving his skin on the rubber mattress, and he got a rash one time.Review of the [Facility Name] Shower Schedule, no date, showed resident #1 had showers scheduled for Tuesdays and Saturdays.Review of resident #1's EHR showed nursing notes regarding showers from 10/21/25 to 11/18/25:-10/21/25 (Tuesday), a shower was documented, -11/4/25 (Tuesday), a shower was documented. 14 days from the prior shower documentation,-11/18/25 (Tuesday), shower was documented. 14 days from the prior shower documentation,During an interview on 12/4/25 at 8:20 a.m., staff member C stated showers were double documented, once on paper which was filled out by the CNAs and once as a task in PCC (Point Click Care).Review of a facility policy titled, Resident Showers, not dated, showed:- .1. Residents will be provided showers/baths as per request or as per facility schedule protocols.,- 18. Complete paper documentation indicating completion of shower and other related questions. Provide completed shower sheet to Nurse for signature and progress note entry.- 19. Nurse to enter progress note that shower was completed and if any skin conditions/concerns .,- 20. Ensure shower completion is documented in electronic POC under PRN tasks,- 21. If bathing was refused by resident please follow process on paper documentation. Resident is to be approached and shower request is to be made 2 times by CNA at least 2 hours apart.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure the basic ADL (activities of daily living) of teeth brushing was completed and documented for 1 (#9) of 12 sampled residents. Findings include:During an interview and observation on 12/3/25 at 8:00 a.m., resident #9 stated he had not brushed his teeth yet for the day, but wanted to wait until he was done eating breakfast. There was a piece of paper hanging off of resident #9's light shade on the wall. This piece of paper showed: . Complete/assist w/ oral care . Thank you, Speech TherapyDuring an interview on 12/3/25 at 12:48 p.m., resident #9 stated no staff member had helped him brush his teeth yet. He stated one staff member talked about doing it but because of an interruption with physical therapy, the task was not completed. Resident #9 stated interruptions in care were not a new issue. He stated he felt he had no consistent schedule in the day and stated physical therapy had never offered to help him brush his teeth.During an interview on 12/3/25 at 4:38 p.m., resident #9 stated he had not brushed his teeth for the day. NF3 stated they were unaware resident #9 had not brushed his teeth for the day and said NF3 could help him today.During an interview on 12/4/25 at 8:30 a.m., staff member D stated, I'm not surprised, when asked if any residents complained about their teeth not getting brushed. Staff member D stated some of the CNAs are great and will do all of the ADLs without having to ask them and some of CNAs do not.Review of a facility policy titled, Activities of Daily Living (ADLs), not dated, showed: . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure physician wound orders were followed correctly for 1 (#1) of 12 sampled residents. Findings include:During an observation and interview on 12/3/25 at 11:49 a.m., staff member M removed resident #1's old wound dressing. Observation of the old wound dressing showed a yellow substance similar to xeroform, along with the old gauze and tape dressing supplies. Staff member M stated the substance was calcium alginate. Staff member M stated they added this to resident #1's wounds, as the wound had not been healing, and staff member M felt the calcium alginate would help. Staff member M stated they were not wound certified, and this was not what the wound certified PT had ordered for resident #1's wound treatment. Staff member M stated resident #1 had been at the facility for several months, with no wound improvement, and thought this addition would help with the drainage from the wound. Additionally, during the dressing change, staff member M did not perform proper hand hygiene after the old dressing had been removed, before placing the new clean dressing.Review of resident #1's physician order, with a start date of 10/29/25, showed: . Cleanse with wound cleanser . apply collagen pad to the base of the wound, secure with a dry dressing .Review of a facility policy titled, Wound Treatment Management, no date, showed: . 1. Wound treatments will be provided in accordance with physician orders .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure: a shower room contained a pull cord attached to the call light system for 1 (#6), appropriate interventions were consistently in place to prevent falls for 1 (#5), and failed to ensure 1 (#10) had appropriate interventions resulting in falls with head injuries for 12 sampled residents. Findings include:1. Resident #6During an interview on 12/3/25 at 4:21 p.m. , resident #6 stated he was left alone in the shower room for 45 minutes on 11/10/25. He stated there was no pull cord and he was wheelchair bound.During an observation and interview on 12/3/25 at 6:18 p.m., the shower room that resident #6 mentioned had no pull cord for the call light station on the wall. The call light station was also out of reach to staff members as there were shower chairs in the walkway. Staff member H stated no resident should be left in the shower room unattended as that was an unsafe practice. The shower room, without the call light availability and shower chairs, created a hazardous area. 2. Resident #5During an observation and interview on 12/2/25 at 3:40 p.m., NF1 stated resident #5 had been falling a lot lately in the facility. NF1 stated resident #5 would also get bumps, scrapes, bruises, and opened skin areas that none of the staff members knew anything about when NF1 would ask. NF1 was concerned about resident #5's care and interventions associated with resident #5's falls.During an observation on 12/2/25 at 2:33 p.m., resident #5 did not have a fall mat on the ground, but the fall mat was folded up and leaning against the nightstand. There was also no please call don't fall sign present on resident #5's side of the room. Resident #5's roommate had a please call don't fall sign on his side of the room.Review of resident #5's EHR showed a nursing note, dated 10/30/25: Resident continues to be monitored for high fall risk related to restless. [sic]During an interview on 12/2/25 at 4:56 p.m., resident #5 stated, My care is probably not great.During an observation and interview on 12/3/25 at 8:32 a.m., resident #5 had his feet out of the bed and was trying to sit himself up using the grab bars on the side of the bed. Resident #5 stated he wanted his shoes that were located at the end of the bed so that he could stand up. Resident #5 eventually pulled himself up to a sitting position at the edge of the bed. The fall mat was folded up, leaning against the nightstand. The call light had no color or light associated with it, and it was draped over the fall mat, with the button hidden behind the mat. When asked how resident #5 asked for help in the facility, he stated he did not know. When shown the call light, resident #5 pushed the call light button. Resident #5's bed was unlocked and moved a few inches closer to the wall after staff member K had responded, and the resident was transferred from the bed.During an interview on 12/3/25 at 1:26 p.m., NF1 stated in the past and for a long time, resident #5's call light did not have a clip on it. NF1 stated there were many times when NF1 came into resident #5's room, and the call light was nowhere near him. NF1 stated resident #5 had fallen numerous times, and most recently two nights in a row they thought in November (2025). NF1 felt the interventions provided by the facility were not adequate or always followed, which resulted in more bruises and scrapes to resident #5. NF1 stated the facility was now waking resident #5 up at 4:00 a.m., which NF1 felt waking someone up intentionally was wrong, and NF1 stated that most mornings, this did not happen. NF1 stated they were constantly trying to speak to the administration about concerns, including the interventions provided for resident #5's falls. NF1 stated that often they felt shut down or told the right answer by the administration so that NF1 would drop the issue. NF1 stated, I feel like I'm micromanaging his care.During an observation and interview on 12/3/25 at 6:28 p.m., resident #5's bed was unlocked. Staff member G stated a resident's bed should always be locked, as it could contribute to a safety issue if a resident were to try to brace against it. Staff member G exited resident #5's room, and the bed remained unlocked.During an interview on 12/4/25 at 8:20 a.m., staff member C stated the way the facility usually prevented falls was with more frequent checks.During an interview with staff members A, B, and F on 12/4/25 at 11:01 a.m., staff member B stated resident #5's fall mat should have been on the ground and not folded up against the nightstand. Staff member A stated the facility just ordered a bunch of the nice fall mats that did not fold up and remained on the ground at all times. Review of resident #5's Care Plan, with an initiation date of 7/29/25, showed:- Be sure (Resident #5)'s call light is within reach and encourage him to use it for assistance as needed.- Continue to remind (Resident #5) to utilize call light for assistance, colored marked placed to aide him in learning to utilize call light. [sic]- Fall mat placed at bedside to help prevent falls with major injury.- (Resident #5) to be up out of bed and have AM care completed at approximately 0400 (4:00 a.m.) and remain out of bed until after breakfast, due to continued evidence of falls d/t resident discomfort at these times. Date Initiated: 11/10/2025.Review of an IDT Post Event Note, dated 11/10/25, showed: the IDT team did not identify or document a root cause for

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility nursing staff failed to obtain weekly weights and failed to recognize a resident's severe weight loss for 1 (#3) of 4 sampled residents; and failed to ensure residents were monitored and tracked for maintenance of proper hydration status for 3 (#s 1, 3, and 4) of 4 sampled residents. This deficient practice contributed to resident #3's decline in weight and for the development of dehydration, requiring hospitalization for residents #1, 3, and 4. Findings include: 1. Review of resident #3's hospitalist history and physical, for the admission date of 10/3/25, showed: . [Resident #3] is an [AGE] year-old female with a history of CHF (Congestive Heart Failure), CAD (Coronary Artery Disease), CKD (Chronic Kidney Disease) stage III, HTN [Hypertension] and hypothyroidism currently residing at (Facility Name) brought in for decreased responsiveness found to have acute renal failure with severe hyperkalemia . hypotension, lactic acidosis and acute hypoxic respiratory failure. Suspect presentation is from significant volume depletion and infection, most likely bilateral lower lobe pneumonia plus or minus UTI [Urinary Tract Infection].During an interview on 10/21/25 at 3:25 p.m., staff member G said resident #3's fluid intake was monitored and documented and could be found in her medical record. Staff member G was unable to locate the fluid intake information in resident #3's medical record. Staff member G said he was not aware that resident #3 had an abscessed tooth on admission, and he was not concerned with her food or fluid intake. Staff member G did not remember any nausea with vomiting occurring prior to resident #3's hospital transfer. Staff member G said he was not aware resident #3 was taking a diuretic, as a medication aide passes medications in his assigned area.During an interview on 10/21/25 at 4:14 p.m., staff member J said resident #3 was at the facility for a short time before starting to have a medical decline. As resident #3 declined, staff member J was unable to complete weekly weights, as resident #3 had grown weaker, and it was difficult to get the resident out of bed. Staff member J said that when she was finally able to obtain a weight for resident #3, the resident had a 14-pound decline in weight. Resident #3 was not drinking or eating well. She was drinking the high-protein shakes that were ordered. Staff member J said meals and hydration intake were documented by CNA staff, and unfortunately, CNA staff often use NA [Not Applicable] when charting meals and hydration. Staff member J said she was not responsible for the daily monitoring of hydration status for residents; that was a nursing responsibility. Staff member J was responsible for making sure the nutrition was in place and available to meet each resident's needs. Record review of resident #3's Nutritional Services IDT Note, which was a late entry dated 9/25/25, showed resident #3 was admitted post-hospitalization with antibiotic therapy for a urinary tract infection and tooth/jaw infection. The notes showed resident #3 had poor dentition with a dental infection present. Resident #3 was having difficulty with chewing.Review of resident #3's medical record weight documentation showed:9/4/2025; 129.8 pounds9/8/2025; 125.6 pounds9/30/25; 115.8 pounds, a 10.4% weight loss. Resident #3's medical record showed no documentation for her weight for three weeks; and when the weight was taken, there was a severe weight loss of 14-pounds since admission to the facility. Review of resident #3's physician order summary showed an order dated 9/5/2025, which included, Obtain weekly weights; reweigh if >5# difference from previous week in the morning every Mon [Monday].Record review of resident #3's Nutritional Services IDT Note, dated 10/1/25, showed: . WTS: (9/30) 115.8# (9/8) 125.6# (9/4) 129.8#; and,Noted significant wt [weight] loss of -14# (10.8%) x 1mo [month] since admission. Resident has been refusing weekly weights often and therefore have not obtained a weight x 3 wk [weeks]. Resident has had an increase in nausea and loose stools and difficult to get OOB [out of bed] per CNAs. Reported decrease in appetite with intakes averaging 40-60% of meals. Noted dental infection but no plan for surgery as resident cannot afford to pay for out of pocket expenses. [sic]Record review of a physician order for resident #3, dated 9/4/25, showed: Monitor for signs and symptoms of diuretic use such as: Headache; Dizziness; Nausea; Loss of appetite; Upset stomach; Dehydration. Document (Y/N); and notify MD if symptoms persist.Record review of resident #3's Nursing-Skilled Services Note. showed assessments were documented daily from 9/4/25 through 9/16/25, 9/19/25 through 9/23/25, but there were no daily assessments after 9/23/25. 2. Review of resident #1's hospitalist history and physical notes, for the admission date of 1016/25, showed: .Resident #1 is a [AGE] year-old male with morbid obesity with BMI [body mass index] of 73, Type 2 diabetes mellitus, chronic pain who presents from (Facility Name) with altered mental status and associated hyponatremia, UTI, and acute kidney injury. Overall, suspect he has has [sic] a urinary tract infection and associated volume depletion resulting in hyponatremia and acute kidney

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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 0726 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (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 0726 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff were competent in assessing, monitoring, and recognizing clinical changes for a resident with an ongoing clinical decline for 1 (#3) of 4 sampled residents. This deficient practice resulted in the resident developing an altered mental status, dehydration, and acute renal failure which resulted in a hospitalization. Findings include: Review of resident #3's Emergency Department Note, dated 10/3/25, showed: .XXX[AGE] year-old female from a care facility presented to the ED [Emergency Department] with four days of recurrent vomiting, hypotension (systolic in the 60s-78 mmHg [millimeters of mercury]), and altered mental status. On arrival she was minimally responsive and found to be hypoxic . Final Diagnosis: Aspiration pneumonia, Severe hyperkalemia, Acute renal failure, Sepsis .Review of resident #3's hospitalist history and physical, for the admission date of 10/3/25, showed: . (Resident #3) is an [AGE] year-old . brought in for decreased responsiveness found to have acute renal failure with severe hyperkalemia .hypotension, lactic acidosis and acute hypoxic respiratory failure. Suspect presentation is from significant volume depletion and infection, most likely bilateral lower lobe pneumonia plus or minus UTI [Urinary Tract Infection].1. AssessmentsDuring an interview on 10/21/25 at 3:25 p.m., staff member G said he noticed resident #3 had started falling, had increased confusion, and weakness since her admission. Staff member G said that he had not documented the change of condition for resident #3 in the medical record because It was difficult to identify the reason for the increased falls. Staff member G said a daily skilled nursing assessment should have been completed and documented in the medical record, but there was not always enough time when one nurse was assigned 25 or more residents. Staff member G said, if a resident had a change of mental status, it would be addressed in the daily skilled assessment documentation. For a resident with an altered mental status, he would first check the resident's vital signs, and then check the urine for a UTI. If the vitals were within normal range, and the urine was clear, he would then check their lungs, glucose, and look at their medications for possible side effects. Staff member G was unable to find documentation in the medical record to identify when resident #3 started to have the medical decline, and stated resident #3's decline was not reflected in the medical record. Staff member G said the facility provided an annual education skills checkoff and a monthly staff meeting, which sometimes provides training on specific topics. Staff member G said the assessment skills training was through computer modules. During an interview on 10/21/25 at 3:55 p.m., staff member I said she did the initial social services assessment when resident #3 was admitted to the facility, and said resident #3 was able to answer all questions without difficulty and able to make medical decisions for herself. During an interview on 10/22/25 at 8:53 a.m., staff member C said the facility did not provide clinical pathways for nursing staff to utilize when completing resident assessments. Nurses had to rely on their assessment and critical thinking skills to direct interventions for residents found to be below their baseline medical status. Staff member C said nursing staff needed to do a better job when documenting the alert notes and documentation for the communication between care team members. Staff member C mentioned the documentation for resident #3's medical decline was not clear per the medical record. During an interview on 10/22/25 at 9:32 a.m., staff member L said resident #3's altered mental status was reported to her at change of shift. Staff member L said she checked resident #3's vital signs and she had low blood pressure and was very confused. Staff member L called the physician with a report and received an order to transport resident #3 to the hospital for evaluation. Staff member L said she would have documented the vital signs in the medical record and completed an assessment or progress note stating what had occurred. Staff member L was unable to find the vital signs, assessment, or progress note documented in the medical record for 10/3/25, the day resident #3 was sent to the hospital for evaluation. Staff member L said she could not recall specifically what had occurred with resident #3. Staff member L said resident #3 was a skilled nursing resident and a resident assessment was required to be done daily for skilled residents. Staff member L said she was unable to find the daily skilled assessments for resident #3 for the morning she was transported to the hospital for evaluation. Staff member L said the facility provided verbal instructions on specific assessments or information may be included in the monthly staff meetings. If the facility was busy, the information may be provided through email. Staff member L said the facility had provided training on a resident change of condition. During an interview on 10/22/25 at 11:28 a.m., staff member B said a change in a resident's condition should be reported from nurse to nurse so the resident can be assessed, the causes of

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. (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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to ensure necessary dental services were provided for a resident with a documented dental abscess who was pending Medicaid approval for insurance coverage, for 1 (#3) or 4 sampled residents. This deficient practice caused resident #3 to have difficulty eating with a resulting severe weight loss. Findings include:Record review of resident #3's admission history and physical, dated 9/5/25, showed resident #3 had a dental infection and was to complete a 10-day course of two different antibiotics. Resident #3 was scheduled for a follow-up dental appointment before her hospital discharge.During an interview on 10/21/25 at 3:55 p.m., staff member I said Medicaid would cover dental services for residents, and when a resident was unable to cover the expense of medically necessary dental services, the facility had other resources available to pay for the services. Staff member I said she did the initial social services assessment when resident #3 was admitted to the facility. Part of the admission assessment for a resident assesses if the resident had any dental problems or needs care. Staff member I said, the resident's response was recorded in the medical record. Staff member I said she would fill out a dental visit request form so an appointment could be scheduled, if needed. Staff member I said she did not remember filing a request for resident #3, and staff member I was not aware resident #3 had an abscessed tooth.During an interview on 10/22/25 at 10:18 a.m., staff member E said she received a phone call from the dental office to confirm resident #3's appointment and form of payment. The dental office records showed resident #3 had no insurance, and the procedure was estimated to cost $1200.00. Staff member E said the EMR (Electronic Medical Record) showed resident #3 had insurance, but not one that covered dental. Staff member E said she checked with another staff member and was told resident #3 would have to pay for the service. Staff member E said she went to resident #3 to discuss payment for the tooth extraction. Resident #3 said she and her husband did not have the funds to pay. Staff member E said she was not aware that resident #3 had applied for Medicaid or that social services had other resources to pay for the tooth extraction.During an interview on 10/22/25 at 10:32 a.m., staff member M and staff member N said resident #3's Medicaid approval was in a pending status. Staff member N said the facility would have provided the care and funds needed for the extraction and would have been reimbursed by Medicaid after the approval process was completed. Staff member N said the business office was not aware of the appointment with the dentist or the $1200.00 cost for the procedure. This information was never communicated to the business office. Staff member M said the facility would have kept the appointment and made sure the procedure was done if the tooth was infected as it would have affected resident #3's health and well-being.Record review of resident #3's EMR showed resident #3 had Medicaid insurance with an effective date of 9/12/25.During an interview on 10/22/25 at 11:28 a.m., staff member B said resident #3 had an appointment for a tooth extraction before admission to the facility, and that resident #3 didn't have the money to pay for the dental procedure, and nursing staff cancelled the procedure. Staff member B stated, We need to provide education and develop a process to bring monetary issues up the chain (of command) and to the business office. Nursing does not know all the aspects of insurance.Record review of resident #3's Social Service Evaluation, dated 9/5/25, showed: .Resident has obvious or likely cavity or broken natural teeth.Record review of a nursing note for resident #3, dated 9/5/25, showed resident #3 was complaining of a severe tooth ache and requesting pain medication.Record review of a nursing note for resident #3, which was a late entry dated 9/8/25, showed staff member E received a phone call from the oral surgeon's office regarding an upcoming appointment for resident #3's tooth extraction. The oral surgeon's office records showed resident #3 had no dental insurance, and the procedure would cost approximately $1200.00. Staff member E spoke with resident #3 about payment for the procedure. Resident #3 expressed she could not afford the amount and agreed to cancel the appointment.Record review of resident #3's Nutritional Services IDT Note, which was a late entry dated 9/25/25, showed resident #3 was admitted post-hospitalization with antibiotic therapy for urinary tract infection and tooth/jaw infection. Resident #3 had poor dentition with a dental infection present. Resident #3 was having difficulty with chewing.Record review of resident #3's Nutritional Services IDT Note, dated 10/1/25 showed: . WTS: (9/30) 115.8# (9/8) 125.6# (9/4) 129.8#Noted significant wt [weight] loss of -14# (10.8%) x 1mo [month] since admission . Reported decrease in appetite with intakes averaging 40-60% of meals. Noted dental infection but no plan for surgery as resident cannot afford to pay for out of pocket expenses. [sic]Review of resident #3's care plan, initiated 9/17/25, showed a focus for dental and an intervention to coordinate arrangements for dental care and transportation as needed/as ordered

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to provide covid vaccines in a timely manner for 2 (#s 5 and 8) who both got sick with covid, but the facility offered a covid vaccine to 1 (#9) of 12 sampled residents. The failure could have contributed to the size of the COVID-19 outbreak or its spread of it. Findings include:During an interview on 12/2/25 at 2:40 p.m., resident #8 stated she was supposed to be getting the COVID-19 (coronavirus disease of 2019) vaccine. Resident #8 stated she was asked about a month ago if she wanted the vaccine, but she had not received it yet. She stated she wanted the COVID-19 vaccine and said it was . because I don't want to get it (Covid) again.During an interview on 12/3/25 at 4:55 p.m., NF1 stated they had asked the facility three times for resident #5 to get the COVID-19 vaccine. NF1 stated resident #5 was never given a consent or declination form for the COVID-19 vaccination. NF1 stated they were upset no vaccine was given or offered, which could have prevented resident #5 from getting sick when the facility had a COVID-19 outbreak in November 2025. NF1 stated that when the COVID-19 outbreak happened, no one at the facility would tell NF1 what was happening or why the staff members were wearing masks. NF1 stated they had to call the health department to get an answer to why everyone was getting sick. During an interview on 12/3/25 at 6:53 p.m., staff member A stated the flu vaccines were not available from the pharmacy, so they could not be given. During an interview on 12/4/25 at 8:30 a.m., staff member D stated the COVID-19 outbreak in the facility started on Halloween and ended on Thanksgiving. Staff member D stated it was just one resident after the other that got sick, and then eventually the staff got sick also. During an interview and observation on 12/4/25 at 10:09 a.m., staff member E stated resident #5 had a decreased appetite and weight loss as a result of the COVID-19 infection.During an interview with staff members A, B, and F on 12/4/25 at 11:01 a.m., staff member A stated vaccines were not given to residents because the primary physician had recommended all of the residents wait until they were off of isolation, which was around the date 11/12/25. Staff member F stated they did not keep Covid-19 vaccines on hand in the building. Staff member B stated the facility did not have the vaccine available before the Covid-19 outbreak because the pharmacy did not have the vaccine available at that time. Staff member B stated 70 percent of the building had been offered the vaccine as of 12/4/25, but the facility had been slowly going through the building and asking residents if they wanted the vaccine or not. Staff member B stated the infection preventionist would be a better person to talk to, and they were on vacation. Staff member B stated they would try to find an email from the pharmacy regarding the availability of the COVID-19 vaccines. Review of the email from the pharmacy, dated 11/26/25, showed the vaccines would be available to the facility by 12/3/25. The COVID outbreak in the facility started on 10/31/25.Review of resident #9's vaccination information showed the resident was offered a COVID-19 vaccine consent/declination form on 11/23/25. The COVID-19 vaccine was administered on 11/28/25.Review of resident #8's COVID-19 vaccine consent/declination form showed she was asked if she wanted the vaccine on 11/23/25. She had not received the vaccine yet.A request was made for resident #5's Flu and COVID-19 vaccinations and/or declinations, and the facility was not able to provide a consent or declination form, which was noted on the surveyor's request sheet. According to the CDC, The 2025-2026 COVID-19 vaccine is recommended for people ages 6 months and older based on individual-based decision-making . (Centers for Disease Control and Prevention, 2025). The CDC also recommended in adults ages 65 years and older with previous vaccinations, a vaccine could be offered at least every six months (Centers for Disease Control and Prevention, 2025).References:Centers for Disease Control and Prevention. (2025, November 4). 2025-2026 COVID-19 Vaccination Guidance. Retrieved from Centers for Disease Control and Prevention: https://www.cdc.gov/covid/hcp/vaccine-considerations/routine-guidance.html#heading-od-jmebm1w

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to place call lights in reachable and seen areas for 1 (#5); ensure there was safety during showers for 1 (#6); and ensure all call lights worked consistently and appropriately for 8 (#s 1, 8, 9, 10, 11, 12, 13, 14) of 12 sampled residents leading to residents feeling their needs were unmet. Findings include:1. During an observation on 12/3/25 at 8:32 a.m., resident #5 had his call light draped over the fall mat located next to the nightstand. Resident #5 was sitting at the edge of his bed, unable to locate his call light, and was attempting to reach his shoes at the end of the bed. The resident was a fall risk. During an interview on 12/3/25 at 1:26 p.m., NF1 stated that in the past, and for a long time now, resident #5's call light did not have a clip on it to hold it in a location. During an observation and interview on 12/3/25 at 6:28 p.m., staff member G attached the call light for resident #5 at an arm's length away to the left of the resident. The call light was clipped to the bed linen. When asked if the resident could see the call light in this location, staff member G stated they did not know, and they were new to the facility. Staff member G stated they did not know much about the resident or where to properly place a call light for residents with dementia. Staff member G then attached the call light on resident #5's clothing and asked if that would be a better location.2. During an interview with residents #6 and #1 on 12/3/25 at 4:21 p.m., residents #6 and #1 both stated the call light wait time was poor and depended on the staff working for the day. Resident #6 stated he was left alone in the shower room for 45 minutes one day. He stated there was no pull cord, and he was wheelchair bound.During an interview and observation on 12/3/25 at 6:18 p.m., the shower room that resident #6 mentioned had no pull cord. The shower room had a call light station on the wall but this was located on the other side of the bathtub, and there was no cord allowing anyone to reach it. There was also a space between the bathtub and the wall which had numerous shower chairs pushed in that space, not allowing a staff member to reach the call light on the wall if needed. Staff member H stated no resident should be left in the shower room unattended as that was an unsafe practice. Staff member H stated they hoped if a resident was independent with showering, a staff member would be around and close for assistance.3. During an interview on 12/2/25 at 2:40 p.m., resident #8 stated that she or the staff members would have to pull the call light out of the wall sometimes if the call light was not working. During an interview on 12/3/25 at 8:00 a.m., resident #9 stated the average time that he waited for a call light to be answered was 20 minutes. Resident #9 also explained and demonstrated he was unable to move himself in his room due to being in a wheelchair. Resident #9 stated his wheelchair was often locked, he was unable to reach the wheel behind him, and he was unable to pedal with his feet on the ground because he could fall out of his wheelchair. He stated, I just have to wait (for staff).During an interview on 12/3/25 at 8:58 a.m., resident #10 stated she had waited for up to an hour for requests before, or she would be told just a moment by staff, only to wait 45 minutes to get the need met.During an interview with residents #11 and #12 on 12/3/25 at 9:55 a.m., resident #12 laughed when asked how long she waited for a call light to be answered. Resident #11 stated that the longest she waited for a call light to be answered was four hours one time, and on average, would wait about 30 minutes for her call light to be answered. Resident #11 stated that many staff members turn off the call light without taking care of the things the residents need help with and staff would then leave before some of the care was done. Resident #12 then stated, And you never see them again.During an interview on 12/4/25 at 8:02 a.m., staff member I stated the call lights may need adjusting in the wall sometimes or fixed, but usually were not a large issue.During an interview on 12/4/25 at 8:20 a.m., staff member C stated there were no issues with the call lights in the wall, but they would sometimes not work outside of the rooms. Staff member C stated they always worked on the call system status board, so you'd have to walk back to the nursing station to know exactly who was calling.Review of a facility document titled Work Orders, dated 11/1/25 to 11/30/25, showed: 13 call lights had issues and were fixed.During an interview with staff members A, B, and F on 12/4/25 at 11:01 a.m., staff member A did not see a concern with the number of call lights fixed for November 2028, but staff member F stated he felt this was a lot of call lights being fixed in a month, and that might mean there is something ultimately wrong with the system. Staff member F stated that call lights not working could lead to a lot of unhappy residents, so the facility should look into the inconsistencies.4. Review of the facility's grievances regarding call lights from 8/18/25 to 11/2/25 showed:-8/18/25 - Resident #13 wrote: 300 hallway light - for call lights does not work .-10/13/25 - NF2 wrote: Nurse stated He's been here before he knows how to use the call light, light was out of reach and sister had to get it off of curtain. States residents not being heard/needs met. [sic]-11/2/25 - Resident #14