STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275153	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Awe Kualawaache Care Center	10131 S Heritage Rd Crow Agency, MT 59022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 observation, interview, and record review, the facility failed to implement a care plan intervention for foam heel protection intended to prevent skin breakdown for 1 (#3), which increased the risk for recurrence of pressure related skin breakdown for a resident with a history of pressure ulcers to both heels, and the facility staff failed to revise and implement a comprehensive, person-centered care plan to address the use of a high-risk anticoagulant medications, and interventions necessary to monitor for and minimize potential adverse consequences, which increased the risks for unrecognized adverse consequences, including bleeding complications associated with anticoagulant use, for 1 (#5) of 14 sampled residents. Findings include:1. During an observation on 6/1/26 at 4:34 p.m., resident #3 was observed lying in bed without foam heel protection boots on either foot.During a second observation on 6/3/26 at 1:25 p.m., resident #3 was again observed lying in bed without foam heel protection boots in place.During an interview on 6/3/26 at 12:58 p.m., staff member D said resident #3's previous open wounds on resident #3's heels were healed, and the foam boots were utilized as a preventative measure for the prevention of future wounds.During an interview with staff members K and L on 6/3/26 at 1:29 p.m., staff member K said foam boots were no longer being used for resident #3, because the open areas on resident #3's heels were healed, and the foam boots were not in the resident's room. Staff member L stated the foam boots were sometimes used as a preventative measure.Review of resident #3's diagnoses list showed a history of pressure injuries, including a Pressure Ulcer of Left Ankle, Unstageable (severity) (L89.520), dated 5/21/25; Pressure Ulcer of Left Heel, Unstageable (L89.520), dated 5/21/25; and Pressure Ulcer of Right Heel, Unspecified Stage (L89.619), dated 4/4/25.Review of resident #3's comprehensive care plan, last reviewed on 4/21/26, showed, . Focus: Pressure Ulcer: Potential for Impairment: (Resident #3) has pressure ulcers on her Skin (on admit), and she has a potential for pressure ulcer development on other boney [sic] prominences r/t disease process.7/23/25 Rt Heel (unstageable on admit) now a Stage 4 healed 11/19/25; . Lt Heel Stage 3 developed during stay healed 11/20/25; .10/23/25 Rt Heel healing. Revision on: 4/15/26Interventions: . Foam boots while in bed to protect bilateral heels. Date Initiated: 4/16/26. [sic]2. During an interview on 6/2/26 at 10:24 a.m., resident #5 said she was taking a blood thinner medication because staff suspected she had a blood clot.During an interview on 6/2/26 at 3:12 p.m., staff member D said that when a new high-risk medication (like the blood thinner) is initiated, the resident's care plan should be revised to reflect the medication's use and include how the resident should be monitored. Review of resident #5's physician's orders showed an order for Apixaban Oral Tablet 5 MG, dated 5/22/26, Give 5 mg by mouth two times a day for anticoagulant Take two tabs by mouth twice daily for 7 days, then 1 tab by mouth twice daily. [sic]Review of resident #5's comprehensive care plan, last reviewed on 5/26/26, failed to show the identification of the resident's use of Apixaban, the anticoagulant. Further review showed the care plan lacked measurable goals related to safe anticoagulant use, and the plan did not include interventions directing staff to monitor for or report potential adverse consequences such as bleeding, bruising, bleeding gums, nosebleeds, bloody or tarry stools, or other signs and symptoms associated with anticoagulant medication therapy.Review of the facility's policy, Care Plans, (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Person - Centered, revised May 2024, showed, Policy Statement, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation .7. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, .

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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. Based on the interview and record review, a facility staff member failed to notify nursing staff of a resident's initial fall for the immediate assessment to be completed by the nurse to determine the resident's clinical condition or if there were injuries after the fall, and the staff member failed to follow the fall program policies and procedures related to fall reporting, for 1 (#10) of 14 sampled residents. Findings include:Review of a facility-reported incident, submitted to the State Survey Agency on 4/23/26, showed resident #10 was found on the floor in his room by a nurse aide. Resident #10 stated he had a fall from his wheelchair. Nursing staff assessed resident #10 and transferred him via Hoyer lift to his wheelchair. The provider and director of nursing were notified, and the provider ordered that resident #10 be transported via ambulance to the local hospital's emergency room for evaluation. Review of the facility reported incident's investigative findings, dated 4/27/26, showed resident #10 was found on the floor after a fall in the morning on 4/22/26 at 9:02 a.m. Facility staff interviews showed resident #10 had a fall earlier that morning, on 4/22/26, around shift change. Facility staff interviews showed that the fall happened around shift change, but it was not reported immediately to the nurse by the nurse aides. The investigative findings showed that resident #10 was interviewed, as well as nurse aides and nurses. The findings showed that education was provided to all staff on the facility's fall protocol and reporting. The nurse aides involved in the incident were given disciplinary warnings for not following the facility's fall protocol(s) and reporting to the assigned nurse.During an interview on 6/4/26 at 10:42 a.m., staff member B stated resident #10 had two falls on 4/22/26. Staff member B stated the first fall in the morning happened around the time of shift change. Staff member B stated there was miscommunication with nurse aides who did not inform the assigned nurses of the first fall that day. Staff member B stated the nurse aides involved had been interviewed and had received education on informing the assigned nursing staff of a resident's fall as soon as they discovered a fall had happened.Review of resident #10's nursing progress notes, dated 4/22/26 at 10:59 a.m., showed: Note Text: CNA reported resident was on the floor and when asked what happened resident stated he fell out of his wheelchair. CNA reported incident to charge nurse at 0910. assessed resident, checked ROM, Neuro checks, vitals taken, hoyered into Chair, Provider notified, DON Notified and provider ordered resident be sent to ER via ambulance. Will continue neuro checks upon return. [sic]Review of resident #10's nursing progress notes, dated 4/23/26 at 12:46 p.m., showed: Note Text: [Resident #10] fell the morning of 4/22/26, hitting his head. He stated he fell out of his wheelchair. DON & [Physician] notified & order received to transfer to [Hospital] ER for evaluation. At the ER, he was found to be anemic & they transfused a unit of PRBC and then transferred him to [Hospital] for further evaluation & to be admitted . He was admitted with the diagnosis of acute on chronic anemia and closed head injury. [sic]Review of resident #10's electronic medical record showed his readmission to the facility on 4/27/26. Resident #10 received facial abrasions and an abrasion to his left leg stump (prior amputation) from the fall on 4/22/26.Review of a facility policy titled Falls - Clinical Protocol, revised March 2025, showed:Assessment and Recognition . c. While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause.2. the nurse shall assess and document/report the following:a. Vital signs;b. Recent injury.;d. Change in cognition or level of consciousness;. f. Pain;. h. Precipitating factors, details on how fall occurred. 5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure a fortified diet was implemented as ordered for a resident who was at risk for weight loss for 1 (#2) of 14 sampled residents. This failure increased the risk for the resident's continued weight loss and compromised nutritional status. Findings include:During an interview on 6/1/26 at 5:08 p.m., resident #2 reported she has lost weight since she was admitted to the facility. Resident #2 stated staff member D spoke to her regarding weight loss and encouraged her to eat foods she preferred.During an observation and interview on 6/3/26 at 8:14 a.m., resident #2's breakfast meal tray card did not identify the resident as requiring a fortified diet. Staff member H said he was unaware that resident #2 had experienced weight loss and was unaware of any interventions related to the resident's nutritional status.During an interview on 6/3/26 at 8:43 a.m., resident #2 said she was supposed to receive extra butter with meals due to her weight loss; however, staff frequently forgot to provide it.During an observation and interview on 6/3/26 at 8:53 a.m., resident #2's breakfast tray lacked additional butter. Staff member J stated that resident #2 was receiving a normal diet and was unaware that the resident required a fortified diet.During an observation and interview on 6/4/26 at 8:11 a.m., the meal service system had been changed from the previously observed tray card to a printed paper tray ticket that identified the resident's fortified diet order. Staff member H stated that the printed paper tray tickets were a new practice, and they provided more information and served as a better guide for meal service.During an interview on 6/4/26 at 8:16 a.m., staff member G said the printed paper cards were not implemented previously due to the printer not working properly. Staff member G stated examples of a fortified diet included adding milk to mashed potatoes, gravy added to meats, and butter added to foods.Review of resident #2's documented weights showed on 1/26/26, the resident weighed 114 lbs. On 5/25/26, the resident weighed 109 lbs., reflecting an approximate five-pound (-4.39%) loss over the four months.Review of resident #2's diet order showed, Regular Food and Fluids w/NO Restrictions diet Regular (L7) texture, Thin (0) No thickness restrictions consistency, Needs Fortified diet related to CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE (I50.32). [sic]Review of resident #2's comprehensive care plan, last reviewed on 3/31/26, showed: .Focus: (Resident #2) has nutritional problem or potential nutritional problem r/t Dx of CHF on a mechanically altered diet and dependent on staff at meals Increased needs related to wound healing Significant weight loss, may be secondary to inaccurate weights on admit date Initiated: 12/23/2025, Revision on: 01/14/2026.Interventions: .Provide, serve diet as ordered. Monitor intake and record q meal. Regular, MM5, Thin, Fortified Date Initiated: 12/23/2025, Revision on: 01/14/2026. [sic]Despite a documented weight loss, a physician's order for a fortified diet, and a care plan intervention directing staff to serve the resident's diet as ordered, the facility failed to ensure resident #2 consistently received the fortified diet intended to address her nutritional risk and prevent further weight loss.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure monitoring was in place for a resident for adverse consequences associated with the use of an anticoagulant medication that increased the risk of unrecognized adverse drug consequences and complications associated with anticoagulant therapy, for 1 (#5) of 14 residents sampled. Findings includeDuring an interview on 6/2/26 at 10:24 a.m., resident #5 said she was taking a blood thinner because staff suspected she had a blood clot.During an interview on 6/2/26 at 2:52 p.m., staff member P stated that when a resident received an anticoagulant medication, staff monitored for signs of bleeding and ensured the required laboratory work was completed. Staff member P stated that monitoring would be documented in the resident's medical record progress notes.During an interview on 6/2/26 at 2:55 p.m., staff member J said she was unsure what monitoring was required for a resident receiving an anticoagulant medication. After consulting staff member P, staff member J stated that staff should watch for signs such as bleeding gums and nosebleeds.During an interview on 6/3/26 at 2:02 p.m., staff member C stated that monitoring should have been implemented when the anticoagulant medication was initiated for resident #5. Staff member C stated that staff should monitor for adverse effects such as tarry black stools, and anticoagulant monitoring should have been added to the Medication Administration Record (MAR) and/or Treatment Administration Record (TAR).Review of resident #5's physician's orders showed the physician's order for Apixaban Oral Tablet 5 MG, dated 5/22/26, that included Give 5 mg by mouth two times a day for anticoagulant Take two tabs by mouth twice daily for 7 days, then 1 tab by mouth twice daily. [sic]Review of resident #5's progress notes showed a health status note dated 5/2/26, that included (Resident #5) up and about. Requested pain med after she had a nap. Left lower leg with swelling, red and warm to touch. No increased c/o pain. She was started on apixaban today. [sic] Further review of progress notes failed to show the identification of monitoring for adverse consequences associated with anticoagulant therapy, such as bleeding, bruising, bloody stools, tarry black stools, bleeding gums, nosebleeds or other signs and symptoms of hemorrhage.Review of resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May and June 2026 lacked the monitoring for adverse side effects for the use of the anticoagulation medication ordered on 5/22/26.Review of the facility's policy, Anticoagulation - Clinical Protocol, revised March 2025, showed, Assessment and Recognition:1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated; .a. Assess any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications.b. Assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding).Monitoring and Follow-up: .5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. [sic]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff kept a urinary catheter drainage bag off the floor for 1 (#35); and failed to ensure oxygen tubing was changed to prevent contamination of respiratory equipment for a resident who was dependent upon oxygen for 1 (#2) of 14 sampled residents. Findings include: 1. During an observation on 6/4/26 at 7:43 a.m., staff member N entered resident #35's room to administer morning medications. Resident #35 had urinary catheter tubing extending down from his bed ending in a covered bag, which was on the floor. Staff member N helped resident #35 adjust in bed to sit up for taking medications. Staff member N administered oral and ophthalmic medications. Staff member N was moving away from resident #35's bedside to exit the room when this surveyor pointed out the catheter bag on the floor, so the placement of the bag could be corrected. During an interview on 6/4/26 at 9:59 a.m., staff member M stated that nursing staff were to keep urinary catheter bags, used by residents, off the floor. Staff member M stated nurse aides knew to use a hook on the catheter bag to hang the bag from the bed, so the bag was off the floor. Review of resident #35's nursing progress notes, dated 6/1/26, showed a recent hospitalization with diagnoses including Benign prostatic hyperplasia (BPH) with urinary retention and obstruction, and chronic foley catheter use with asymptomatic colonized bacteremia (multidrug-resistant organisms including VRE and ESBL E. coli). Review of a facility policy titled Catheter Care, Urinary, revised August 2022, showed: . The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Infection Control1. Use aseptic technique when handling or manipulating the drainage system.2. Be sure the catheter tubing and drainage bag are kept off the floor. [sic] 2. During an observation and interview on 6/1/26 at 4:33 p.m., resident #2 was observed receiving oxygen through nasal cannula tubing connected to an oxygen concentrator. The oxygen tubing was not dated to show when the tubing was last changed. Resident #2 said the staff did not change the oxygen tubing regularly. During an interview on 6/3/26 at 1:12 p.m., staff member D said oxygen tubing was changed weekly, and the change should be documented and tracked on either the Medication Administration Record (MAR) or Treatment Administration Record (TAR). During an interview on 6/3/26 at 1:17 p.m., staff member L said oxygen tubing should be changed every 72 hours and documented in the resident's electronic health record. Staff member L further stated she typically wrote the date of the tubing change on tape and affixed it to the tubing when the task was completed. During an interview on 6/4/26 at 8:00 a.m., staff member C said resident #2's oxygen tubing should have been dated with tape, and the tubing change should have been documented on the Medication Administration Record (MAR) or Treatment Administration Record (TAR). During an interview on 6/4/26 at 10:11 a.m., staff member M stated that nursing staff were expected to change a resident's oxygen tubing every week. Staff member M stated that if oxygen tubing was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not dated, the nursing staff were supposed to change the tubing right away. Staff member M stated that if there was no sticker adhered to the tubing showing the date it was changed, then it would not be known when the tubing was last changed. Review of resident #2's physician orders for oxygen, dated 12/19/25, showed it was to be administered at 1-6 liters per minute via nasal cannula continuously, day and night, on every shift. Review of resident #2's Medication Administration Record (MAR) and Treatment Administration Records (TAR) for May and June 2026 failed to show any documentation that oxygen tubing changes had been completed.