STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275160	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Rehabilitation and Nursing LLC	1050 Grand Dr Bigfork, MT 59911

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow a planned and approved menu to ensure residents received the expected meals and nutrition. This deficient practice effected residents who ate meals prepared by the facility. Findings include:During an observation and interview, on 12/1/25 at 2:43 p.m., a package of sliced ham was observed in a black bin filled with water, on the three-compartment kitchen sink. Staff member F stated she had thawed out the ham because she did not have what she needed to make breakfast on the menu. Staff member B stated the facility would do substitutions verbally notifying the dietician but did not document the substitutions in any way. Staff member B did not know what the notification to the residents was, if any, of the menu changes when they happened. Staff member B stated the dietician was currently on vacation and the dietary manager was out.Review of the facility menu on 12/1/25, showed breakfast was to be a French toast bake, bacon, fresh fruit, and juice.During an observation on 12/3/25 at 8:41 a.m., residents were served varied eggs, a sausage patty, sliced strawberries, and toast. The posted menu for breakfast was buttermilk pancake, egg of choice, and fresh fruit.During an interview on 12/3/25 at 11:04 a.m., staff member N stated he had asked the cook on duty why the wrong breakfast was served. He was told they had mixed up the days when cooking on Monday so they just swapped the days. Staff member N stated he left a message for the dietician to approve but he was on vacation and could not be reached.Review of the facility's policy titled, Menus and Adequate Nutrition, dated 7/16/25, showed: .3. Menus shall be prepared at least two weeks in advance for timely approval and ordering of food. Menus will be posted in the kitchen and in areas accessible by residents at least one week in advance.4. Menus will be followed as posted. Notification of any deviations from the menu shall be made as soon as practicable. Substitutions shall comprise of foods with comparable nutritive value.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was served with an appetizing appearance and a palatable taste for 3 (#s 16, 18, and 19); and failed to serve altered food diets in an appealing manner for 1 (#28) of 14 sampled residents. This failure affected the residents' satisfaction and enjoyment of their food. Findings include:Review of the facility's lunch menu for 12/2/25, showed the facility served a honey glazed pork chop, baked potato, cauliflower, baked roll, and fruit cobbler.1. During an observation and interview on 12/2/25 at 12:30 p.m., resident #28 was sitting at her table in the dining room. She was eating lunch from a three-way sectioned plate that had a watery textured pureed meal. The plate contained three different watery purees in each separate section of the plate. All pureed items on the plate appeared to be white/beige in color. It was not obvious which section of the plate contained which food item. The resident asked the surveyor for sugar for her porridge. The meal was a pureed pork chop, baked potato, and cauliflower. The meal served to resident #28 did not include porridge.2. During an observation and interview on 12/2/25 at 12:32 p.m., resident #16 was sitting at the dining room table with a plate of food that contained a pork chop which appeared thin, dry, and hard. The baked potato and cauliflower were cut up together, and it was difficult to tell the baked potato from the cauliflower on her plate. Resident #16 asked the surveyor to try a bite of the meat on her plate because it tasted bad. She stated the pork chop and the entire meal was, just awful, and she did not want to eat anything on her plate because it was so bad. She stated she could not even chew the pork chop it was so hard and dry. Resident #16 stated the meat, and the meals were not very appetizing. Several other residents at the table nodded and verbalized agreement with the food tasting bad. By the end of the meal service resident #16 had only consumed approximately one third of the entire meal. Resident #16 stated she had mentioned the poor food quality before and nothing changed.3. During an observation and interview on 12/2/25 at 4:07 p.m., resident #18 was sitting in his wheelchair next to his bed. On his bed was the meal tray from lunch which consisted of a pork chop, baked potato, cauliflower, white roll, and fruit cobbler. The resident did not eat anything on the plate except for a bite of the pork chop. The pork chop appeared dry and hard. Resident #18 stated the lunch that day was terrible, and everything was the same color white. He stated the pork chop was not edible and had to spit out the one bite he took. He stated he could not cut the pork chop with his fork or the butter knife, so he picked it up and took a bite of it. He stated it took him 30 minutes to chew the meat and ended up spitting it out. Resident #18 stated he could not eat anything on his plate because it looked so bad and the meat tasted so bad. He stated, unfortunately, this meal was actually really good for what they were usually served. Resident #18 stated he had mentioned this to staff and administration, but nothing changed. He stated the facility did change meat suppliers and felt some of the meat was a little better than it had been, but today the meat was terrible. 4. During an interview on 12/2/25 at 4:22 p.m., resident #19 stated the food did not seem to have any nutritional value and everything tasted the same. He stated the meals were not enjoyable and often were difficult to cut or chew. The resident stated the only thing they had to look forward to in the facility was the meals and they were terrible. He stated at his age, 93, enjoying a good meal should not be too much to ask. Resident #19 stated he had mentioned this to staff and administration, but nothing changed. A test tray was ordered and sampled by the survey team on 12/2/25 at 1:07 p.m. The test tray contained a thin, dry, and plain pork chop with no seasoning which appeared to look white, a half of a baked potato, boiled cauliflower, a white dinner roll, and a fruit cobbler in a bowl. The entire plate of food appeared bland with no seasoning and did not have any color, everything on the tray was white in color. There was no seasoning on any of the meal items. The pork chop was not able to be cut with a fork and was difficult to cut with a butter knife. The pork chop was dry and tasted like it was old or freezer burnt. The baked potato was bland and slightly [NAME]. The cauliflower tasted bland. The roll was bland to taste.During an interview on 12/3/25 at (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8:51 a.m., staff member A stated some of the residents complained that the menu gets old. He stated the menu was provided by Grove, a food distributor and the food was delivered by Sysco. He stated the menu rotated and changed seasonally. Staff member A stated they did recently change meat distributors because the residents were unhappy with the meat from the previous distributor. He stated he was not aware the residents continue to be unhappy with the meals being provided. He stated there was a food council right after resident council and the feedback was provided to the dietary manager.During an interview on 12/4/25 at 8:32 a.m., staff member N stated he was not aware of any food concerns or the residents' concerns with food palatability.During an interview on 12/4/25 at 10:12 a.m., staff member B stated they were aware some of the residents did not like the food and they had recently changed meat distributors. She stated they utilized Grove, a food service company, that created the meal plans and menus, and the food was delivered by Sysco.

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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 food was stored and distributed to residents in their rooms in a sanitary manner to protect food from cross contamination, food borne illnesses, and improper infection control practices. This practice had the potential to affect all residents receiving food delivered to their room. The facility failed to store, prepare, and serve food under sanitary conditions. This practice effected all resident who ate food prepared by the facility kitchen. Findings include: 1.During an observation on 12/2/25 at 12:58 p.m., staff member K was preparing to distribute the lunch service meal trays to residents in their rooms. The meal trays were loaded on a large, wheeled cart, that was not enclosed. There were 11 uncovered maroon colored bowls that contained a dessert. The beverage glasses on the cart were also uncovered. During an interview on 12/2/25 at 12:58 p.m., staff member K stated she was not aware if the drinks or the bowls with the dessert needed to be covered. During an interview on 12/2/25 at 1:00 p.m., staff member F stated she did not have anything to cover the bowls or the cups. During an interview on 12/4/25 at 8:32 a.m., staff member N stated it was brought to his attention the other day that they did not have lids that fit the bowls and glasses. He stated he just ordered an insulated cart for room service meals and lids that would fit the dishes. During an interview on 12/4/25 at 10:12 a.m., staff member B stated it was the expectation that food items delivered to residents in their rooms were covered. She stated the barrier to ensuring items were covered was because they did not have covers for the bowls or the glasses and there was a general lack of oversight in the kitchen. 2. During observations of the initial kitchen tour and interviews, on 12/1/25 between 2:27 p.m. to 3:10 p.m., showed: Staff member F doing dishes in the dish room with no hairnet on, the window of the dish room behind where the clean dishes dry had dust buildup with dead bugs, the top of the window had a strip of the trim/paint peeling down. The tray serving line had a long white cutting board that had heavy dark stains and deep gashes that were not cleanable surfaces. Staff member B called staff member N on the phone and she was told they put actual cutting boards or trays over the white board. Staff member B stated she could just remove it if not used and she placed it against the garbage can. The bottom of the cutting board and the metal counter below it was covered in milky looking water. An upright white freezer had brown dirty streaks along the outside. Inside there was no thermometer, every shelf was covered in a thick layer of frost and all of the bread and buns were freezer burnt. Two bags of tortillas with an expiration of 8/6/25. Staff member F stated the kitchen staff would go by the date on the package of the bread until opened, in which case the bread would be used up or thrown away in three days. Staff member F stated she would date and initial when she opened items but could not speak for other staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A stand mixer had a dirty ripped clear plastic bag over the top. The bag had splashes and powders spilled on it, inside the mixer bowl was brown congealed spots. A large garbage bin was against the mixer where used food and other refuse was thrown away. Staff member B stated the mixer was broken and not in use and had to get an electrician out to work on it. A three drawn metal cart had serving and cooking utensils piled in, the drawers had oversized liners that were covered in crumbs and debris from the stove. The stove and oven were covered in splashed and spilled food in tan and brown chunks, streaks of grease, and dust on all surfaces. The handwash sink did not have a barrier to keep debris from the three-compartment sink and the metal prep table with the toaster directly on both sides. The toaster was filled with brown charred crumbs. The three-compartment sink had a black tub of water with a package of ham sitting in it. Staff member F stated she had thawed the ham out for breakfast as she did not have the proper ingredients for the menu items. A small white freezer had frost buildup and no thermometer with a mix of foods and debris. The walk-in cooler temperature logs had missing entries for November 2025 on the following dates: 15, 16, 20, 21, 22, 23, 26, 27, 28, 29, 30, 31 and had 12/1/25 temperature written below. There was sliced cheddar cheese in plastic wrap without a date or label, Tupperware with a blue lid with a green food, Tupperware with a green lid with diced fruit, and a Tupperware with a green lid with peas, none had a label or date. A clear bin on the top shelf had four half sandwiches with the date of 1/30. The walk-in freezer temperature log was missing entries for November 2025 with the following dates: 1, 2, 3, 8, 9, 14, 15, 16, 20, 21, 22, 23, 26, 27, 28, 29, 30 and 31. Dusty towels were up on top of the walk-in fridge/freezer next to a fan/motor. A window over a metal prep table had splashes of food, dust, and several unsecured large knives sitting on the sill. A mounted can opener on the metal prep table had grease and shavings buildup with a congealed red/brown substance at the bottom. Staff member B stated the food delivery truck for the holiday had come early and they had not been able to fit everything, and the can opener was not in working condition, so it had not been used. Staff member B stated she had been using a hand can opener for all canned goods. Microwave on metal prep table had grease inside and on the door. On a shelf above the metal prep table, clear plastic bins of flour, sugar, brown sugar, corn meal, had no dates. A box of granola ¾ gone had no date, and condiment cups of powdered sugar looking substance, had no date or label. A half-used bag of chocolate chips with no date, 12 pie crusts with no date or label. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The bottom shelf of the metal prep table had a stack of cutting boards all leaning on metal bowls, pans and strainers tipped the wrong way. A bag of crackers were open on the shelf of seasonings with no label or date. The shelf was covered in spilled seasonings. Staff member B stated she was never given logs for the two white freezers and she had written in the 12/1/25 temp on the walk-in cooler and freezer logs of November because she did not have a December log. The dining area and staff member N's office, the office had shelves filled with various snacks and beverages. They were not sealed or labeled and dated. During an observation of the kitchen on 12/2/25 at 11:54 a.m., the kitchen had the same issues as the initial observation for dust, debris, spills, and bugs. The long white cutting board was back on the tray line with the same stains and deep uncleanable grooves. A roll of kitchen knives was on the metal prep table with blue tape on some handles, which are not a cleanable surface. The walk-in freezer outer thermometer still showed error. During an interview on 12/3/25 at 10:43 a.m., staff member N stated he worked with a dietician who came to the facility one time a month and would do a test tray. Staff member N stated he had some PIPS (performance improvement projects) in place for the kitchen but needed to adjust them and add more with the initial tour findings. Staff member N stated prior to the initial tour the two white freezers did not have thermometers or temperature logs. Staff member N stated the food in his office was for staff snacks. Staff member N did not know who the backup to him and the dietician would be if they were both out, as they were on 12/1/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's wheelchair was clean and well-maintained, and the soiled wheelchair bothered the resident, for 1 (#22) of 14 sampled residents. Findings include:During an observation on 12/1/25 at 3:15 p.m., resident #22 was laying in his bed. His wheelchair was next to the bed. The wheelchair had a large amount of piled up, brown and black dried and slivered debris as well as a sticky appearing debris on the frame of the wheelchair by the locks, on the arm rests, as well as the peddles. During an observation and interview on 12/2/25 at 9:19 a.m., resident #22's wheelchair had a large amount of piled up, brown and black dried and slivered debris as well as a sticky appearing debris on the frame of the wheelchair by the locks, on the arm rests, as well as the peddles. The resident stated he could not remember the last time his wheelchair was cleaned. He stated he preferred it to be clean, and it bothered him to have so much food debris all over it. During an observation on 12/3/25 at 8:47 a.m., resident #22's wheelchair had a large amount of piled up, brown and black dried and slivered debris as well as a sticky appearing debris on the frame by the locks, on the arm rests, as well as the peddles.During an interview on 12/4/25 at 8:31 a.m., staff member E stated the expectation was to wipe down and clean resident wheelchairs weekly or as needed. He stated they currently did not keep a log of when the residents' wheelchairs were cleaned.During an interview on 12/4/25 at 10:12 a.m., staff member B stated they did not have a process established yet for cleaning wheelchairs. She stated it was her expectation going forward that wheelchairs would be cleaned by the night shift staff, at least two times a week, or as needed if the wheelchair was heavily soiled. She stated they were not sure when the last time resident #22's wheelchair had been cleaned.Review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Equipment, with an implementation date of, 4/11/25, showed, Policy: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations to break the chain of infection.A request was submitted to the facility on [DATE] for a wheelchair cleaning log for resident #22. The requested documentation was not provided by the end of the survey.

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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 observation, interview, and record review, the facility failed to ensure comprehensive, person-centered care plans were developed and implemented for a resident with a left hand contracture and who had a diagnosis of Post Traumatic Stress Disorder for 1 (#25), and a resident who required physical therapy for 1 (#31), and the facility failed to care plan the risks and interventions for a resident's weight loss and swallowing risks for 1 (#28) of 14 sampled residents. The deficient practice increased the risk of decline in range of motion, re-traumatization, physical function and weight loss. Findings include:1. During an interview on 12/2/25 at 9:02 a.m., resident #25 stated she had not been seen by a provider for treatment of her post-traumatic stress disorder. Resident #25 became tearful when asked about the history of trauma and endorsed a history of traumatic events. During an observation on 12/2/25 at 9:22 a.m., resident #25 was observed with her left hand contracted. Review of resident #25's admission MDS with an ARD of 10/28/25, showed under section I6100 (diagnosis), that resident #25 had a diagnosis of post-traumatic stress disorder. During an interview on 12/4/25 at 7:25 a.m., staff member B stated she was informed of resident #25's left-hand contracture on the day prior. Staff member B stated there would not be anything on the care plan because she was unaware of the contracture. Review of resident #25's EHR showed a diagnosis of left-hand contracture, dated 10/22/25, the day resident #25 was admitted to the facility. Review of resident #25's Comprehensive Care Plan, last reviewed on 11/26/25, failed to show the identification of the left-hand contracture, goals for caring for the contracture, and interventions to prevent further decline. The comprehensive care plan also lacked identification of resident #25's history of trauma and did not identify triggers of her trauma. 2. During an interview on 12/1/25 at 3:05 p.m., resident #31 reported that one of her biggest concerns about her care was the lack of physical therapy. Resident #31 stated she would have to go ask them (the staff) about when or how often she was to be seen by therapy. Review of Physician's Order, dated 8/5/25, showed, .Description: PT order per [Physician Name] at [Facility Name] Ortho: PT eval and treat for muscle strengthening and active assisted ROM 2-3x/week 8-10 weeks. [sic] Review of resident #31's Comprehensive Care Plan, last reviewed on 11/25/25, showed, .Focus: The resident has limited physical mobility r/t weakness, Date Initiated: 8/28/25. Goal: The resident will demonstrate the appropriate use of to increase mobility through the review date. Revision on: 9/6/25 . [sic] Physical Therapy interventions were not listed on resident #31's Comprehensive Care Plan as it related to prior therapy effectiveness, duration or the need for future assessment for continued (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy. 3. During an interview on 12/3/25 at 1:03 p.m., staff member B stated that the dietary manager and dietician went to the nutrition at risk meeting. The dietician attended, usually by teleconference, he was responsible for assessments, MDS completion, and care planning any changes for a resident's nutrition. Review of resident #28's diagnosis list showed a diagnosis of CR(E)ST (autoimmune disorder), which has the potential for swallowing difficulty. Review of resident #28's progress notes showed she had a choking incident on 11/9/25 and had to go to the emergency room to have the piece of pork chop removed. Her new orders were to puree her food. Review of resident #28's care plan, last reviewed 10/26/25, showed no care area related to the choking incident or resident #28's diet and weight loss. Review of the facility's policy, Comprehensive Care Plans, date implemented 4/11/25, showed, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality and incorporate culturally competent and trauma-informed care as indicated. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident.

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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 interview and record review, the facility failed to provide regular showers for 2 (#s 21 and 31) of 14 sampled residents. Findings include:1. During an interview on 12/1/25 at 2:28 p.m., NF1 stated there were weeks where resident #21 did not receive a shower. NF1 further stated resident #21 was supposed to have had a shower two times per week.Review of resident #21's Baseline Care Plan, dated 3/9/25, showed resident #21 preferred to have showers two times per week.Review of resident #21's Comprehensive Care Plan, last reviewed on 9/29/25 showed, .Focus: [Resident Name] has an ADL self-care performance deficit r/t hx CVA, Date initiated: 5/19/25. Goal: [Resident Name] will maintain current level of function in ADLs through the review date. Interventions: BATHING/SHOWERING: [resident name] requires maximum assist by 1 staff with bathing and showering one time week and as necessary - per her preference. [sic]Review of resident #21's Tasks List for showers for the last 30 days showed resident #21 had a shower once per week.Review of the weekly shower schedule, updated 11/6/25, showed resident #21 was scheduled twice per week for showers on Tuesdays and Fridays.2. During an interview on 12/1/25 at 3:05 p.m., resident #31 stated she had concerns about the lack of showers she had received, and she preferred her showers in the evening on Tuesdays and Fridays. Resident #31 stated she did not receive her showers in the evenings as she preferred.During an interview on 12/2/25 at 4:48 p.m., staff member C stated that all residents needed to be supervised in the shower room and there was no resident who was independent with showers. Staff member C said there were barely enough staff to complete evening showers.Review of resident #31's Showering Task List for the last 30 days showed that resident #31 had received one shower.Review of the weekly shower schedule, updated 11/6/25, showed resident #31 was scheduled twice a week on Tuesdays and Fridays during the night shift.Review of resident #31's Comprehensive Care Plan, last reviewed on 11/25/25, showed, .Focus: ADL, Resident has a risk for decline in ADL function related to weakness, date initiated 8/28/25, Goal: The resident will improve or maintain current level of function through the review date .Interventions: BATHING/SHOWERING: The resident is able to: Perform independently.Review of the facility's policy titled, Resident Showers, implemented on 12/4/25, showed: Policy: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulated circulation, and help prevent skin issues as per current standards of practice.Policy Explanation and Compliance Guidelines: 1. Residents will be provided showers as per request or as per facility schedule protocols and based upon resident preferences and safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275160	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Rehabilitation and Nursing LLC	1050 Grand Dr Bigfork, MT 59911

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to identify a resident's contracture, risk factors of the contracture, and failed to assess and implement preventative measures to prevent further decline in the contracture, for 1 (#25) of 14 sampled residents. This deficient practice increased the risk of the resident's contracture worsening. Findings include:During an observation on 12/2/25 at 9:22 a.m., resident #25 was observed with her left hand contracted.During an interview on 12/4/25 at 7:18 a.m., staff member M stated she thought there was something on the TAR about it (left hand contracture) but could not find anything in the orders regarding resident #25's left hand contracture. Staff member M did note the left-hand contracture was listed on the CNA task sheet.During an interview on 12/4/25 at 7:19 a.m., staff member L stated she was unaware of resident #25's left hand contracture.During an interview on 12/4/25 at 7:25 a.m., staff member B stated she was informed of resident #25's left hand contracture on the day prior. Staff member B stated there would not be anything on the care plan because she was unaware of the contracture.Review of resident #25's EHR showed a diagnosis of a left-hand contracture, dated 10/22/25, the day resident #25 was admitted to the facility.Review of resident #25's Care Conference Summary form, dated 11/5/25, showed, .2. Nursing SummaryA. List any Problems/Needs/ConcernsWants therapy for her knees and left-hand contractures. [sic]Review of resident #25's Comprehensive Care Plan, last reviewed on 11/26/25, failed to show the identification of the left-hand contracture, goals for caring for the contracture, and interventions to prevent further decline.Review of resident #25's admission MDS with an ARD of 10/28/25, Section GG - Functional Abilities showed, .GG0115. Functional Limitation in Range of MotionCode for limitation that interfered with daily functions or placed the resident at risk of injury in the last 7 daysA. Upper extremity (shoulder, elbow, wrist, hand)0. No impairment .The contracture was not identified on the admission MDS assessment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify the risks and put interventions in place to prevent a significant weight loss of 12 percent over 41 days, for 1 (#28) of 14 sampled residents. Findings include:During an observation on 12/3/25 at 8:47 a.m., resident #28 was in the dining room for breakfast, and her food was pureed in separate containers. Resident #28 had eaten some food and was trying to get a condiment container of brown sugar open to eat, but did not know what it was.During an interview on 12/3/25 at 10:52 a.m., staff member N stated he went to nutrition at-risk meetings, and they would determine as a team what interventions were needed for a resident. Staff member N stated that nursing would monitor residents' weights.During an interview and observation on 12/3/25 at 11:51 a.m., staff member L looked up resident #28's chart and stated resident #28 had a choking incident on 11/9/25 and had been downgraded to a pureed diet that the resident hated. Staff member L stated resident #28 had also been placed on a diuretic since she was re-admitted to the facility on [DATE].During an interview on 12/3/25 at 12:52 p.m., staff member B stated resident #28 was downgraded to a pureed diet after a choking incident, and resident #28 hated the diet. Staff member B stated she had reached out to a sister facility (of the company) to try and obtain a speech therapy evaluation for resident #28 to determine if the diet could be upgraded, but the therapist was not available until 12/10/25. Staff member B stated the facility had recently put a new plan in place to change the frequency and parameters of obtaining weights on residents, but the nutrition at risk committee had not met in December 2025 to review weights yet.Review of the Dietician Progress Note dated 11/10/25, . [Comparison Weight 10/26/2025, 130.4 Lbs, -11.0% , -14.4 Lbs]; Recent addition of diuretic, consumign 82% of meals. Will confirm wt, but wt loss would be favorable r/t diuretic use [sic] Review of resident #28's weights from 10/24/25 to 12/3/25, showed:10/24/25 weight of 125.5 lbs.11/3/25 weight of 116 lbs.11/11/25 weight of 118 lbs.12/2/25 weight of 112.6 lbs.12/3/25 weight of 110.4 lbs. Resulting in a 12% weight loss.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review, the facility failed to identify a resident's past history of trauma and identify triggers that may cause re-traumatization for 1 (#25) of 14 sampled residents. This deficient practice increased the risk for the resident to experience trauma that could have been prevented. Findings include:During an observation and interview on 12/2/25 at 9:02 a.m., resident #25 stated she had not been seen by a provider for treatment of her post-traumatic stress disorder. Resident #25 became tearful when asked about the history of her trauma and she endorsed a history of traumatic events.Review of resident #25's admission MDS with an ARD of 10/28/25, showed under section I (active diagnoses), Psychiatric/Mood disorder, I6100: resident #25 had a diagnosis of post-traumatic stress disorder.During an interview on 12/3/25 at 2:16 p.m., staff member A stated trauma informed care assessments were not being completed.A request was made for resident #25's trauma assessment on 12/3/25 at 2:18 p.m.Review of resident #25's Resident Trauma Interview, dated 12/3/25, showed the trauma interview was not completed until the day it was requested by the survey team.Review of resident #25's Comprehensive Care Plan, last reviewed on 11/26/25, lacked identification of resident #25's history of trauma and did not identify triggers of her trauma.Review of the facility policy titled, Trauma Informed Care, implemented on 6/15/25, showed,Policy: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment, and others.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure specialized rehabilitation services were delivered as ordered by the physician and failed to further assess and monitor for the need for continued specialized therapy services for 1 (#31) of 14 sampled residents. This deficient practice limited the opportunity for the resident to achieve her highest level of physical function. Findings include:During an interview on 12/1/25 at 3:05 p.m., resident #31 reported concern about the lack of physical therapy she had received. Resident #31 stated she would have to go ask them (the staff) about when or how often she was to be seen by therapy.Review of resident #31's, [Facility Name] Healthcare Discharge Orders, dated 7/28/25, reflected resident #31 was to be seen by physical therapy twice weekly.Review of Physician's Order, dated 8/5/25, showed, .Description: PT order per [Physician Name] at [Facility Name] Ortho: PT eval and treat for muscle strengthening and active assisted ROM 2-3x/week 8-10 weeks. [sic]Review of resident #31's Baseline Care Plan, dated 7/25/25, showed, .B. Therapy, 1. Ordered therapy services: e. No therapy indicated at this time.Goal of therapy services2. Physical-Functional goals: b. Learn adaptive techniques at a new level of functioning.The baseline care plan failed to show the need for ongoing therapy.Review of resident #31's Comprehensive Care Plan, last reviewed on 11/25/25, showed, .Focus: The resident has limited physical mobility r/t weakness, Date Initiated: 8/28/25.Goal: The resident will demonstrate the appropriate use of to increase mobility through the review date. Revision on: 9/6/25 [sic]Physical Therapy interventions were not listed on resident #31's Comprehensive Care Plan as it related to prior therapy effectiveness, duration or the need for future assessment for continued therapy.Review of resident #31's physical therapy documentation showed the following:Physical Therapy Initial Examination, document date 7/31/25, showed, .Plan: Frequency: 2-3 times a week, Duration: 8 weeks.Daily Note/ [NAME] Sheet, dated 8/21/25, .Assessment/Diagnosis: .She will continue to benefit from skilled care to address her impairments and promote her highest level of function post op.Daily Note/Billing Sheet, dated 9/4/25, .Assessment/Diagnosis:.She will continue to benefit from skilled care to address her impairment and promote her highest level of function post op.Long term goals:.Documentation and services listed above were reviewed and approved by the therapist supervising treatment and deemed to be medically indicated and necessary.Daily Note/Billing Sheets, dated 9/11/25, .Assessment/Diagnosis:.Moving forward, the patient will benefit from continued physical therapy focusing on strengthening exercises, motor activation, and balance activities to improve hip function and mobility.Discharge Note, dated 10/15/25, .[Resident name] has been discharged from our care for the following reasons: Patient will be discharged from PT at this time due to financial barriers.Resident #31 was seen by physical therapy three times since she was admitted to the facility on [DATE].During an interview on 12/3/25 at 3:36 p.m., staff member B stated she had to be assertive with the physical therapy assistant to fit people into their schedule because residents were not being seen as ordered.During an interview on 12/3/25 at 4:31 p.m., staff member A stated the facility did not have in-house therapy and therapy services were provided by therapists in the community. Staff member A said when therapy was needed residents were sent out for services. Staff member A said resident #31 was seen for therapy a couple times and she did cancel a couple of times. Staff member A reported resident could not pay the co-pay for the therapy services and was subsequently discharged from the services due to financial reasons. Staff member A stated resident #31 was Medicaid pending status at the of discharge from therapy services and had since been approved for Medicaid. Staff member A reported resident #31 was not reassessed for therapy after she was discharged because the staff assumed she was doing better because she was no longer using a wheelchair and was using a walker. Staff member A said there was no formal agreement or contract with the company who provided therapy services to the facility.Review of the facility's policy titled, Specialized Rehabilitative Services, implemented on 4/11/25, showed, Policy: (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility shall provide or obtain services from an outside resource for specialized rehabilitative services if required by the resident's comprehensive assessment and care plan. These services will assist them in attaining, maintaining, or restoring their highest practicable level of physical, mental, functional, and psycho-social well-being.Policy Explanation and Compliance Guidelines:1. Specialized rehabilitative services include but are not limited to the following: a. Physical Therapy.2. Specialized rehabilitative services will be provided under the written order of a physician by qualified personnel.3. The services will be provided or coordinated by qualified personnel. In-house providers and outside resource providers.4. The care plan for individuals receiving specialized rehabilitative services will be monitored and revised as indicated by a licensed professional.5. Specialized rehabilitative services are considered a facility service and included within the scope of facility services; therefore, if services are not enumerated in the State plan, the facility will not charge a Medicaid recipient for specialized rehabilitative services.