STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275126	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation	1301 E Broadway Missoula, MT 59802

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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. 48261 Based on interviews and record review, the facility failed to honor a resident's right to privacy by entering the residents' room without consent and going through residents' items for 2 (#s 6 and 14), and the practice upset the two residents involved; and the facility failed to ensure residents had the opportunity to engage in political voting for 2 [#s 5 and 19] of 24 sampled residents, and #5 and 19 wanted to vote if able. Findings include: RIGHT TO PRIVACY: During an interview on 11/5/24 at 9:27 a.m., resident #6 stated staff member K went through her drawers without permission, and she entered her room to find staff member K standing in her room with two knives in the air saying, Look what I found. Resident #6 stated, She was snooping in our drawers while we were out of the room. They were buried in a drawer. We used to cut fresh fruit like apples and such but haven't used the knives in a long time, so they have just stayed in the drawer. Resident #6 stated, A shouting match started, there's no respect, she (staff member K) said she was doing a deep clean. No one asked us or told us about a deep clean. During an interview on 11/5/24 at 10:31 a.m. resident #14 stated he had returned from lunch and found staff member K going through his dresser drawers. Resident #14 stated, They have no right to come in our room and go through our drawers without asking and without us present, and stuff always seems to happen when we go to appointments, out of the building, stuff just disappears. No respect. We have told them to stay out of our room when we are not here. During an interview on 11/5/24 at 12:32 p.m., staff member C stated she was not aware of a screaming match between resident #6 and staff member K. Staff member C stated she had heard resident #6 was refusing services from staff member K and staff member K was told to discuss the refusal with staff member I. During an interview on 11/5/24 at 4:01 p.m., staff member A stated she had interviewed resident #6, and resident #6 was now stating the screaming was on her part and staff member K did not scream back. Staff member A stated resident #6 and resident #14 agreed with a plan to allow all housekeeping staff to enter the room, if both residents were present. (continued on next page)

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	During an interview on 11/6/24 at 8:30 a.m., resident #6 stated she did not agree to allow staff member K into her room. Resident #6 stated, I do not want (staff member K) in our room at all, and no male housekeepers, as females are better cleaners. I did not agree to all housekeeping staff in here (her room). During an interview on 11/6/24 at 9:00 a.m., with staff members K and L, staff member L stated she had told residents #6 and #14 the week prior to the scheduled deep cleaning, but had no documentation of notifications or consents. Staff member L stated staff member K did enter the room on 10/10/24 to complete the deep cleaning as scheduled. A review of a facility-reported incident, dated 11/5/24 - 11/6/24 reflected: - Resident #6 stated she did not want staff member K in her room; - Resident #6 and resident #14 will be notified in advance of a deep cleaning schedule, so the residents could be present. A review of the facility's, Deep Clean Training Module, no date, reflected: 1. Always knock, wait and announce who you are, let them know your deep cleaning. . 9. With personal items, pick up, wipe, and put back in place. 10. We do not go through their [residents] stuff unless they are there going through it with you. RIGHT TO VOTE: a. During an interview on 11/4/24 at 1:08 p.m., resident #19 stated she had not received her ballot to vote. Resident #19 stated she told the activities staff she had not received her absentee ballot, but staff had not followed-up with her to assist her with voting. Staff member A was notified by the State Survey Agency surveyor that resident #19 was requesting to vote. b. During an interview on 11/5/24 at 8:20 a.m., staff member A reported staff member E would obtain an absentee ballot for resident #19 so she could vote. During an interview on 11/5/24 at 11:01 a.m., staff member B stated staff member E interviewed residents when they admitted to the facility, in order to determine the resident's interest in voting. Staff member E was to also determine if the resident voted absentee or at their voting location. Staff member B stated she was not aware of any follow-up completed to ensure those residents who reported a desire to use the absentee ballot received one. Staff member B stated an audit was currently in progress after resident #19's voting and ballot concern was brought to the facility's attention. 44770 c. During an interview on 11/5/24 at 10:20 a.m., resident #5 stated she did not get to vote but she wanted to. It was election day, and her roommate was able to vote by mail. Resident #5 said she did not get a ballot in the mail, but she would love to vote if it was still possible. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, Resident Rights, dated 1/11/24, reflected, . The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44770 Based on observation, interview, and record review, the facility failed to accommodate a resident's needs when he was sitting in his wheelchair, and complete an assessment for positioning aids, for 1 resident (#7) of 2 sampled residents with one sided weakness who require a wheelchair for mobility, but he was unable to hold up his torso/head, which would often lean forward. Findings include: During an observation on 11/4/24 at 4:11 p.m., resident #7 was sitting in his wheelchair in his room. His body was leaning far forward in the chair. Resident #7 appeared to be sleeping. During an observation on 11/6/24 at 8:23 a.m., resident #7 was in the dining room. He was sitting in his wheelchair, leaning forward with his face almost touching his food. Resident #7 was dozing off, but when his face would touch his plate, he would sit back up. During an interview on 11/6/24 at 9:41 a.m., staff member Q said resident #7 liked to stay in his wheelchair. She said he tipped (leans) forward frequently, and she would try to get him back to his room. She said sometimes he wouldn't want to go. She said she did not know if he required any kind of positioning pillow or equipment to help him be more comfortable in his wheelchair. During an observation on 10/6/24 at 3:14 p.m., resident #7 was leaning over in his chair in the dining room, and one foot was on the floor, the other was on the foot pedal. He was bent over so far, his head was almost touching his knees. During an observation on 10/7/24 at 8:12 a.m. resident #7 was sitting in the dining room, in his wheelchair, falling asleep. He was leaning forward in his wheelchair. The wheelchair did not have foot pedals. Resident #7's head was touching the edge of the table, and there was a CNA sitting behind him, assisting another resident. Staff member R asked resident #7 if he wanted to go back to his room. Resident #7 said, Sleep, sleep. Staff member R stated, This doesn't look very safe, referring to how the resident was sitting. Staff member S came over to the table and instructed staff to put the foot pedals on the resident's wheelchair to keep him from falling out. Staff member R stated, you were almost falling out of your chair. Resident #7 stated, Sleep, sleep, and at 8:35 a.m., staff member R repositioned resident #7 in the chair. During an observation on 10/7/24 at 9:14 a.m., resident #7 was observed in the dining area, with his head on a pillow, on the table. During an interview on 10/7/24 at 9:16 a.m., staff member T stated physical therapy and occupational therapy used a different system to document their assessments. She stated she had never assessed resident #7 for positioning in his wheelchair. She stated if there had been an assessment for positioning done, it would be updated in the resident's EMR. A request was made on 10/7/24 for physical therapy or occupational therapy notes for resident #7's positioning. A progress note from physical therapy was provided, which was dated after the surveyor made the request. No other physical therapy notes or occupational therapy notes were provided prior to the end of the survey. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #7's Focus area on the care plan showed, [Resident #7 name] has potential for falls related injury due to impaired mobility and balance from right sided hemiplegia, right wrist drop, generalized weakness and muscle atrophy, pain and use of narcotic medication, cognitive impairment, and incontinence. Under the Interventions section, there was one intervention related to resident #7's wheelchair, which showed, If [#7's name] is sleeping in his wheelchair, nursing staff will wake him and ask [#7's name] if he wants to rest in his bed. There were no interventions regarding the resident's positioning in the wheelchair on the care plan. Review of a nursing note dated 6/1/24 at 2:01 a.m., showed resident #7 was found on the floor on his right side next to his wheelchair. He complained of pain to his right shoulder.

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 48261 Based on interviews and record review, the facility failed to make personal funds available to residents on the same day, for amounts less than $100 for Medicare residents or $50 for Medicaid residents, on weekends for 3 (#s 6, 14, and 23) of 24 sampled residents. This practice required residents to wait until business hours on Monday to access their personal funds for food, drinks, activities, or outings. Findings include: During an interview on 11/4/24 at 1:43 p.m., resident #14 stated he could not access his personal funds from his resident trust account on weekends for soda from the vending machine. During an interview on 11/5/24 at 9:37 a.m., resident #6 stated she was not able to access her personal funds on the weekends and would also have to find someone willing to give her change for the vending machines. Resident #6 stated the staff have told her they were discouraged from making change for residents. During an interview on 11/5/24 at 10:34 a.m., resident #23 stated she could not access her resident trust fund on the weekend and would beg staff for change in order to use the vending machine. Resident #23 stated she was told residents had to wait until Monday to get their funds from staff member M. During an interview on 11/5/24 at 11:40 a.m., staff member N stated she would send residents to the weekend manager on duty for any questions about access to their personal funds on the weekend. During an interview on 11/5/24 at 12:01 p.m., staff member B stated the rotating managers on the weekend do not have access to petty cash. Staff member B stated as far as she knew the only person with access to petty cash was staff member M. The staff would then call staff member M, if the funds were for an emergency. Staff member B stated if the funds requested on the weekend were not an emergency, the request would be processed on the following business day. During an interview on 11/5/24 at 12:23 p.m., staff member H stated residents could only exchange money from the petty cash on the weekends, but could only access personal accounts during the week. Staff member H stated a previous employee had started the process of training a weekend receptionist to manage resident trust accounts, but the training had not been completed when the employee terminated her employment. During an interview on 11/5/24 at 3:11 p.m., staff member M stated the facility was looking for a new weekend receptionist and would then train the new employee to use petty cash for resident access to their trust account funds on the weekend. Staff member M stated education was needed for residents and staff to understand residents would have access to personal funds on the weekends. Staff member M stated she did not have any examples of residents who received personal funds on the weekend in the past 12-months. Review of a facility policy, Resident Trust Funds, dated 6/20/24, reflected: (continued on next page)

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	- .Residents should have access to petty cash, on a routine basis, and be able to arrange for access to larger funds, when needed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48261 Based on observations, interviews, and record review, the facility failed to ensure residents knew how to file a grievance and provide residents an option for reporting grievances anonymously, for 4 (#s 6, 14, 23 and 41) of 24 sampled residents. Findings include: During an interview on 11/5/24 at 9:27 a.m., resident #6 stated she had a complaint regarding an incident that occurred in early October. Resident #6 stated she did not know what a grievance was and was worried about retaliation, if the staff knew she had complained. During an interview on 11/5/24 at 10:31 a.m. resident #14 stated he had a grievance about staff showing no respect for his privacy and not being able to access his resident trust account on weekends. Resident #14 did not know how to file a grievance or how to submit one anonymously. During an interview on 11/5/24 at 10:34 a.m., resident #23 stated she could not access her resident trust account on weekends and would beg staff for change in order to use the vending machine. Resident #23 stated she was told residents had to wait until Monday to access their resident trust account funds from staff member M. Resident #23 stated she did not know how to file a grievance or how she could file one anonymously. During an interview on 11/5/24 at 11:01 a.m., staff member B stated the facility did not have a location in the facility where a resident could file an anonymous grievance. During an interview on 11/5/24 at 11:40 a.m., staff member N stated residents turn grievance forms into the Social Worker, Director of Nursing, or a staff member will turn in the form for the resident. Staff member N stated she was not aware of a way for residents to turn in a grievance anonymously. During an observation of the facility on 11/6/24 at 10:05 a.m., no grievance boxes were available for residents to place an anonymous grievance form. The only location found to obtain a grievance form was between the front office and the nursing station. No forms were available in other areas of the building. During an interview on 11/6/24 at 8:01 a.m., NF2 stated resident #41 had dentures when she was admitted to the facility. NF2 stated he asked several staff about where resident #41's dentures were, but staff stated they were not able to locate them. NF2 stated he went to the previous administrator about resident #41's missing dentures. NF2 stated he was not aware of a grievance process or how to file a grievance. NF2 stated he assumed the facility would address resident #41's missing dentures after he complained to the administrator. A review of the facility's Grievance Log, dated October 2023 to November 2024, reflected no grievances filed by residents #6, 14, 23, and 41 for their concerns mentioned above. Review of the facility's Grievance Policy, dated 4/22/24, did not reflect instructions on how to file a grievance anonymously.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on interviews and record review, the facility failed to ensure the accuracy of the Quarterly MDS assessment, for medications and hearing, for 2 (#s 11 and 23) of 24 sampled residents. Findings include: 1. During an observation and interview on 10/6/24, staff member P walked into resident #11's room. Resident #11 was having a hard time hearing the surveyor's questions. Staff member P stated, Let me get her hearing aid. Staff member P put one hearing aid in resident #11's ear. The hearing aid did not help resident #11's ability to hear. Review of resident #11's EMR, showed her Care Plan showed resident #11 used two hearing aids. A Significant Change MDS, on 9/16/24, showed resident #11 did not use hearing aids, but she had highly impaired hearing. A Quarterly MDS, dated [DATE], showed resident #11 did not use a hearing aid and had highly impaired hearing. A Quarterly MDS on 5/31/24 showed resident #11 did use hearing aids, and she had moderate hearing difficulty. During an interview on 10/7/24 at 11:17 a.m., staff member G stated, I don't even do those assessments. I can see that it did not get pulled in correctly. I have never really noticed that it had an error in there before. But this one is definitely inaccurate because according to the assessment she does have hearing aids. I will submit modifications for both of those (MDS assessments) right away. 48261 2. A review of resident #23's EHR MDS record, reflected an MDS, dated [DATE], which showed resident #23 was on an antibiotic for the last seven days. A review of resident #23's EHR, Physician Orders, dated 10/1/24 - 11/7/24, reflected no antibiotics were ordered or given to resident #23. During an interview on 11/4/24 at 1:44 p.m., resident #23 stated she was not on any antibiotics and did not know why antibiotics would be listed in her health records. During an interview on 11/5/24 at 4:11 p.m., staff member G stated he had reviewed the medications in October and November (2024) for resident #23 and was not able to find an antibiotic ordered. Staff member G stated he would be completing a correction for the MDS, dated [DATE].

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48262 Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for a resident's foley catheter care within 48 hours of admission for 1 (#61) of 4 sub-sampled residents with a urinary catheter. Findings include: During an observation and interview on 11/6/24 at 3:09 p.m., resident #61 was observed sitting in a chair, in the activities room. Resident #61 stated he discharged from the hospital on 10/9/24. Resident #61 stated the foley catheter was placed in the hospital, and he was hoping it would be removed soon. During an interview on 11/7/24 at 10:46 a.m., staff member B stated resident #61 was admitted to the facility on [DATE]. Staff member B stated the nurses were responsible for developing baseline care plans for residents on admission. Staff member B stated the admission assessment would trigger care areas for the resident's baseline care plan. Staff member B stated she did not know why resident #61's baseline care plan did not address resident #61's foley catheter. Staff member B stated the nurse could have possibly missed checking the box on the assessment. A review of resident #61's baseline care plan, dated 10/9/24, showed resident #61 was admitted on [DATE]. The baseline care plan did not show any focus areas, goals, or interventions for resident #61's foley catheter.

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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. 48262 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan, for a resident receiving anticoagulant medication, for 1 (#61) of 7 sub-sampled residents receiving anticoagulation therapy. Findings include: Review of resident #61's medical record showed resident #61 was prescribed and taking an anticoagulant medication for the diagnosis of atrial fibrillation; Eliquis. During an interview on 11/7/24 at 10:46 a.m., staff member B stated the interdisciplinary team was responsible for ensuring care plans remained current. Staff member B stated high risk medications, such as anticoagulants, should be included on resident care plans for monitoring side effects. Staff member B stated resident #61's current care plan did not reflect the use of an anticoagulant medication, which was for the Eliquis. Review of resident #61's current care plan, with a revision date of 10/25/24, did not show resident #61 was prescribed an anticoagulant medication (Eliquis), or the need to monitor for potential side effects of the medication to ensure the resident's safety.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48261 Based on observations, interviews, and record review, the facility failed to review and revise the comprehensive care plan after Quarterly and Annual assessments, for 1 (#41) of 24 sampled residents. Findings include: During an observation and interview on 11/4/24 at 1:21 p.m., resident #41 was sitting in the hallway greeting other residents and staff as they passed by. Resident #41 did not have her dentures in her mouth. Resident #41 stated she did not have her dentures because somebody took them. Resident #41 stated she had to find soft foods to eat because she did not have her dentures. During an interview on 11/4/24 at 1:40 p.m., staff member O stated resident #41 had not had dentures for as long as she had been living at the facility as far as she was aware. Staff member O stated she was not aware the care plan showed resident #41 had dentures. During an interview on 11/6/24 at 9:14 a.m., staff member C stated the care plan did have an active intervention for denture care twice daily. Review of resident #41's Nursing Care Plan, with a last revision date of 9/9/24, reflected: - . {Resident #41} has upper and lower dentures. Assist her with oral/denture care twice daily and as needed. Date initiated: 2/25/21.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 44770 Based on observation, interview, and record review, the facility failed to replace a missing hearing aid for 1 resident (#11) of 1 sampled resident who required hearing aids. This deficiency affected resident #11's ability to hear since July of 2024. Findings include: During an observation and interview on 10/6/24, staff member P walked into resident #11's room. Resident #11 was having a hard time hearing the surveyor's questions. Staff member P stated, Let me get her hearing aid. Staff member P put one hearing aid in resident #11's ear. The hearing aid did not appear to help resident #11's ability to hear. Review of resident #11's Care Plan showed resident #11 used two hearing aids. During an interview on 10/6/24 at 3:52 p.m., staff member B said resident #11 had been missing a hearing aid since sometime in August (2024). She said, There had been one (hearing aide) missing and found, then another one missing and found. She said typically the process for replacing a lost hearing aid would be (the concerned party) to fill out a grievance form and then follow the pathway from there. Staff member B stated she neglected to fill out the grievance form for resident #11's missing hearing aid when it went missing originally. Staff member B said staff was getting close to (#11's) ear and yelling, for now. She said there really wasn't anything they could do until resident #11 was able to get the hearing aids replaced. During an interview on 10/6/24 at 3:49 p.m., staff member U stated, Back in July (resident #11) went to Costco with her friend because she dropped her hearing aid and ran it over. Her ear had a lot of buildup in it, so we had to make an appointment for her on August 26th, 2024, (at the audiologist) to get the wax taken care of. Resident #11 was sick the day of the appointment, so she did not go. She had a new appointment with the audiologist November 26th to get her ears cleaned, and the Costco appointment was scheduled for December 16th, 2024. I made those appointments for her today. During an interview on 10/7/24 at 1:17 p.m., staff member V, stated she had taken over the position of Social Services in August (2024). She said she did not know anything about resident #11's missing hearing aid. Review of a facility policy titled, Hearing and Vision Services, dated 4/22/24, showed: It is the policy of this facility to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities . 1. Employees should refer any identified need for hearing or vision services/appliances to the social worker/social service designee. 2. The social worker/social service designee is responsible for assisting residents, and their families, in locating and utilizing any available resources . for the provision of the vision and hearing services the resident needs. (continued on next page)

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	275126	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation	1301 E Broadway Missoula, MT 59802

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Once the vision or hearing services have been identified the social worker/social services designee will assist the resident by making appointments and arranging for transportation .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48262 Based on observation, interview, and record review, the facility failed to record medication refrigerator temperatures daily and add dates to medications when opened. This deficient practice may negatively affect any resident who utilized the facility's refrigerated medications if the refrigerator temperatures were not maintained or medications were used beyond expiration dates. Findings include: During an observation on 11/7/24 at 11:06 a.m., one medication refrigerator was identified located on Hall B in the medication storage room. A thermometer was located inside the refrigerator. One vial of Tuberculin Purified Protein Derivative (PPD), 1 ml, was observed to be previously opened. The half empty, multi-dose vial, was not dated with the date the vial was originally opened. No refrigerator temperature logs were found during the observation to show the temperatures were within a safe range. During an interview on 11/7/24 at 10:37 a.m., staff member B stated refrigerator temperature logs were located at the nurse's station. Staff member B stated the medication room and carts were checked by nurses on all shifts. Staff member B stated a new process had recently been implemented because the facility identified problems and wanted to improve compliance. Review of facility documents, titled, Refrigerator Temperature Log, dated October and November 2024, showed no documentation for 27 out of 31 days in October 2024. November 2024 showed no documentation for four out of seven days.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. 48261 Based on observations, interviews and record review, the facility failed to ensure a resident was referred for dental services after dentures were lost, while the resident was living at the facility for 1 (#41) of 24 sampled residents. This practice led to resident #41 being required to eat soft and pureed foods, and the facility had the opportunity to address the concerns over an extended period of time, and had multiple opportunities to correct the concerns, but did not. Findings include: During an observation and interview on 11/4/24 at 1:21 p.m., resident #41 did not have her dentures in her mouth. Resident #41 stated she did not have her dentures because somebody took them. Resident #41 stated she had to find soft foods to eat because she did not have her dentures. During an interview on 11/6/24 at 8:01 a.m., NF2 stated resident #41 had dentures when she was admitted to the facility. NF2 stated he asked several staff about the missing dentures, but the dentures were not found. NF2 stated he went to the previous administrator about the missing dentures and getting resident #41 new dentures, but the facility never scheduled resident #41 for a denture appointment. NF2 stated resident #41 would benefit from having her dentures, and he had shared his concerns with the management team during care conferences last year. NF2 stated resident #41 had plenty of money to cover new dentures if the facility would not take responsibility for the lost dentures. During an interview on 11/6/24 at 9:14 a.m., staff member C stated she reviewed the EHR and found the lower denture was lost on 10/26/21 but no record was found of when the upper denture went missing. Staff member C stated the facility would schedule a dental appointment for resident #41. Review of a facility policy, Dental Service, dated 4/22/24, reflected: - . 1. The facility will provide or obtain from an outside resource, routine and emergency dental services to meet the needs of each resident. - . 5. The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location . Review of resident #41's dietary tickets from the facility kitchen, dated 11/6/24, reflected resident #41 received pureed meats and soft foods, including pudding, ice cream, and applesauce. Review of resident #41's Nursing Care Plan, with a last revision date of 9/9/24, reflected: - . {Resident #41} has upper and lower dentures. Assist her with oral/denture care twice daily and as needed. Date initiated: 2/25/21 .

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 44770 Based on observation, interview, and record review the facility failed to provide assistive utensils for 1 (#11) of 2 sampled residents. This deficiency affected resident #11's ability to handle her utensils while eating and increased her risk of weight loss. Findings include: During an observation on 11/6/24 at 8:15 a.m., resident #11 was in the dining room and using regular silverware while eating her meal. She was having difficulty keeping the food on the silverware and struggling to lift her silverware to her mouth without spilling the food on herself and the floor. Resident #11's tray card showed she was to receive Built up utensils (adaptive silverware). Resident #11 was not observed to have built up utensils at the dining table. During an interview on 10/6/24 at 11:32 a.m., staff member W stated there was only one resident who required assistive utensils. The resident name she provided was not resident #11. She stated there was usually a communication slip that would show them when a resident had an order for assistive utensils. She did not know resident #11 required assistive utensils. During an interview on 10/6/24 at 3:23 p.m., staff member B said was unaware resident #11 required special utensils. She stated typically when the dietician requests special equipment for a resident she receives the communication and sends it out to staff. During an interview on 10/7/24 at 9:04 a.m., staff member X stated, I write whatever the changes are on the communication slip. It goes to the kitchen first and gets put on the ticket (the dining tray card). She stated it was the kitchen's responsibility to supply the assistive utensils and to ensure the resident received them. Review of resident #11's dietary progress note, dated 10/31/24, showed resident #11 had been followed by the dietician for weight loss. The dietician noticed resident #11 was able to handle the utensils more easily if she used assistive (adaptive) utensils. Resident #11's care plan focus areas lacked information about the assistive utensils or risk of weight loss if not using them.

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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. 48261 Based on observations, interviews, and record review, the facility failed to ensure call lights were within reach for 3 (#s 5, 37, and 55) of 24 sampled residents, and the residents were not able to reach or use the call lights. Findings include: During an observation on 11/6/24 at 9:41 a.m., resident #5's call light was under her bed, with the bed against the wall. Resident #5 could not reach the call light. During an observation on 11/6/24 at 9:43 a.m., resident #37's call light was out of reach, on a nightstand on the right side, approximately two feet back from the bed. Resident #37 stated she did not know where her call light was located. During an observation on 11/6/24 at 9:44 a.m., resident #55's call light was on the nightstand, approximately one and a half feet away from the bed. Resident #55 stated she did not know where her call light was located. During an observation and interview on 11/6/24 at 9:46 a.m., NF1 stated he had just arrived and was not aware of the location of the call lights for residents #5, 37, and 55. NF1 stated the call lights for residents #5, 37, and 55 were not within reach, when observed with the surveyor. NF1 stated he would expect all call lights to always be within reach of the residents. During an interview on 11/6/24 at 11:01 a.m., staff member B stated the call lights should always be within reach of the residents. Staff member B then called out on the staff radio system for all call lights to be checked to ensure they were within reach of the residents. Review of a facility policy, Resident Rights, dated 1/11/24, reflected: - The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.