STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275025	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalispell Rehabilitation and Nursing LLC	171 Heritage Way Kalispell, MT 59901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to address the lack of housekeeping services and concerns with missing laundry, which had been complained about in the resident council for several months, but the issues were ongoing. This failure affected any resident who did not have their concerns addressed or whose room/area they were in was not maintained by housekeeping. Findings include: Review of Resident Council minutes from September 2025 to December 2025 showed:-September - requests/concerns for laundry and housekeeping, and the residents requested deeper cleaning in their rooms, especially the toilets, and the dining room. -October - request/concerns for laundry and housekeeping, to include continuing to want deeper cleaning in the resident rooms, with a focus on fixtures and toilets, and missing laundry items, which were gone for up to a month or more. -November - requests/concerns for laundry/housekeeping were that laundry items continue to go missing for long periods of time, and residents again requested deeper cleaning pf their rooms.-December - requests/concerns for laundry and housekeeping were that laundry continued to take long period of time before items were returned, if they were, and residents would like housekeeping to pay more attention to cleaning their floors, especially under their beds.During an observation and interview on 12/16/25 at 12:20 p.m., staff member R stated the resident's personal laundry was put in bins for the respective units. The laundry department had tried different ways to limit laundry issues, including using mesh labeled bags, but the bags were not consistently used by nursing to ensure the correct laundry made it back to the resident(s). Staff member R stated when they knew whose clothes they were, they would label them (with the resident's name), but a lot of the clothes came in unlabeled. T Staff member R stated many times that the inventory for a resident was not filled out completely, or the items were brought in at a later time, and the inventory was not updated to reflect the new items. If the missing items could not be found, they would be replaced. During an interview on 12/17/25 at 1:06 p.m., staff member N stated there were complaints about the lack of cleaning at the facility, which was brought up in Resident Council, and there were individual concerns brought forth. Staff member N stated the B hall was not cleaned very often. Other residents also had grievances, which stemmed from their rooms not being cleaned thoroughly. Refer to F584 related to more concerns identified for housekeeping and laundry services.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to maintain a clean environment for the residents and failed to ensure the laundry for the residents was managed and returned to them in a timely manner; including not providing the labeled clothing to the correct resident(s), which resulted in an altercation between 2 (#s 1 and 2) of 24 sampled residents. Findings include:Laundry:During an observation and interview on 12/16/25 at 12:20 p.m., staff member R stated the resident's personal laundry was put in bins for the respective units. The laundry department had tried different ways to limit laundry issues, including using mesh labeled bags, but the bags were not consistently used by nursing to ensure the correct laundry made it back to the resident(s). Staff member R was observed putting labels on several items for the residents, and stated when they knew whose clothes they were, they would label them (with the resident's name), but a lot of the clothes came in unlabeled. Then the laundry staff would not know who the clothes belonged to. Staff member R stated laundry staff would then hang these unmarked items on a rack on each hall, in case a resident was missing an item, then it could possibly be found. Staff member R showed the entire laundry area and the hall racks, where some of the clothing racks had a significant amount of unlabeled laundry, and the staff had no idea who the items belonged to. Staff member R stated that if a resident thought they were missing a piece of laundry, usually the laundry would fill out a missing item form, and include as much information as possible for the description, and then staff would start to look through the laundry to try and locate it. Often, an item was still being washed, or it was not labeled. If the items could not be found, a grievance form would be filled out, and they would search the residents' room and their inventory to try and locate it. Staff member R stated many times that the inventory for a resident was not filled out completely, or the items were brought in at a later time, and the inventory was not updated to reflect the new items. If the missing items could not be found, they would be replaced. Staff member R stated they would keep the unidentified clothing for a few weeks, but had limited space due to the amount of unlabeled and unclaimed clothes, being stored.During an interview on 12/17/25 at 12:26 p.m., staff member N stated the two male residents in the grievance form, dated 12/3/25, were involved in a facility-reported incident, which was an altercation between the two residents on 12/1/25. Resident #1 recognized his clothes, but the clothes were being worn by resident #2 at the time, and #1 thought the clothes were stolen. The facility found out that resident #2 was wearing the wrong clothes, which were labeled with resident #1's name, which was crossed out, and resident #2's name had been written under it. Review of a grievance, dated 12/3/25, showed resident #1, Saw resident wearing a shirt he claims is his. blue and white shirt. Would like it back . found the resident wearing the shirt. Checked and found staff had misplaced shirt. [sic]Review of facility grievance logs, from July 2025 to December 2025, showed:-7/8/25 for missing clothes-9/10/25 for resident council laundry concerns-9/25/25 for missing clothing and blankets-12/3/25 for missing items for two residents and clothes seen on another resident-12/10/25 for missing blankets-12/10/25 for missing clothingDuring an interview on 12/17/25 at 4:28 p.m., staff member B stated the understanding was for nursing to put resident clothes in the mesh laundry bags so they would not get lost. Sometimes family did not want laundry marked.Review of the facility policy titled, Resident Personal Belongings, dated 7/1/25, showed, .3. All resident personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the medical record.4. Additional possessions brought in during the duration of the individual's stay shall be added to the existing personal belongings inventory listing.6. The facility will ensure resident belongings are kept in a neat and orderly fashion and maintained in each resident's room.Maintaining a Clean Environment:During an observation on 12/15/25 at 4:58 p.m., the E hallway had multiple dried brown spills along the length of the hall, with four bug sticky traps in the corner, by an exit, that had dust and bugs stuck to them.During an observation on 12/16/25 at 12:18 p.m., the E hallway had the same brown spills along the length of the hall, with the bug traps still in place. During an observation on 12/17/25 at 7:27 a.m., the facility halls smelled of urine, the floors on the E hall had the same brown dried spills as what was previously observed on 12/15/25 and 12/16/25, and more new spills were observed. During an observation of the facility units on 12/17/25 from 9:25 a.m. to 10:27 a.m., showed:E hall:-Double door to hallway regular/deep clean sign had no dates on it.-Four bug traps in the back corner covered in bugs and dust with debris of leaves and dirt around them from the door.-Room E1 had a very large brown spill that was dried, and it went across the floor, directly in front of the resident's bed, with obvious shoe and wheel marks going through it. The housekeeping cleaning

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations and findings of abuse timely to the State Survey Agency, for 3 (#s 10, 11, and 21) of 24 sampled residents. Findings include: Resident #21: Review of a facility reported incident, dated 6/7/25, showed an alleged incident of physical abuse occurred between staff members NF6 and NF7, and resident #21, on 6/6/25 at 2:25 a.m. The event was an abuse allegation, but not reported to the State Survey Agency within the required two-hour time frame, and the final findings for the reported incident were not submitted within the required five working days. During an interview on 12/17/25 at 3:33 p.m., staff member A stated there were technical issues with the abuse reporting system that caused the initial reporting delay for the incident that occurred on 6/6/25, with resident #21. Residents #10 and 11: During an interview on 12/17/25 at 4:32 p.m., staff member A stated facility staff were to report abuse to him immediately, but tried to have the report received no later than two hours after it occurred. Staff member A stated he did not know why the facility reported incidents would show in the system as late reporting. Staff member A stated an incident in January 2025 was a late report because the nurse did not report it to him, and the event was found later in a chart review, then it was reported late. The nurse was re-educated on the reporting requirements. Staff member A stated he sometimes had technical difficulties when trying to report to the State Survey Agency, but he would get them submitted before the deadline. Staff member A stated they followed the new reporting guidance for the five-day final investigations. Review of a facility reported incident, showed the event occurred on 1/25/25, and it was a verbal altercation between residents #10 and #11. The event was reported initially on 1/27/25, after a chart review. The event was not reported until two days after it occurred; therefore, it was a late report. Review of a facility policy, titled Abuse, Neglect and Exploitation, dated and implemented 4/11/25, reflected the following: .Reporting/Response. a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. B. The Administrator will follow up with the government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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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** Based on interview and record review, the facility failed to accurately identify wandering behaviors on the MDS Resident Assessments for 1 (#15) of 24 sampled residents. This failure limited the facility's ability to implement appropriate care planned interventions to prevent foreseeable harm to a resident with dementia and a known behavior of wandering daily. Findings include:During an interview on 12/16/25 at 11:51 a.m., staff member C stated he was not aware resident #15 had a history of wandering before being admitted to the facility on [DATE]. Staff member C stated he assumed the questions on the admission MDS Resident Assessment Instrument pertained to only current behaviors in the facility, not behaviors before admission. Staff member C stated he did not review resident #15's medical diagnoses when filling out the admission MDS Resident Assessment. He did review all the progress notes in resident #15's electronic medical record. Staff member C stated he was aware of the importance of an accurate MDS assessment because it helped guide the care a resident should receive. Staff member C stated that if he had known resident #15 was wandering every day, he would have changed the MDS assessment to accurately reflect her care needs. He stated he would initiate interventions that would be more appropriate on the care plan to promote the resident's safety and that of other residents residing on the memory care unit. Staff member C stated he would review previous and current medical records, along with all progress notes, and interview residents and or family members, before filling out any MDS Assessments in the future. During an interview on 12/16/25 at 12:20 p.m., staff member M stated MDS assessments were coded based on what the documentation in a resident's medical record showed, and if the MDS Assessment was coded correctly for resident #15, the care plan interventions would be different to address the resident's wandering every day. Review of resident #15's admission MDS Resident Assessment and Care Screening in her electronic health record, signed as completed on 8/15/25, showed on page 15, section E0900, that the resident did not have wandering behaviors, and under the Presence & Frequency section, it showed the resident did have an active diagnosis of Wandering on page 24. Review of resident #15's Quarterly MDS assessment, in her electronic health record, signed as completed on 11/14/25, showed the resident had wandering behaviors every one to three days on page 15, section E0900 Wandering - Presence & Frequency, and it was not daily as was actually occurring with the resident.Review of resident #15's electronic health record, under the Medical Diagnosis tab, with a date of 8/12/25, showed on admission she had the following diagnosis: WANDERING IN DISEASES CLASSIFIED ELSEWHERE. Review of resident #15's EHR, under the Progress Notes tab, reflected that resident #15 had daily incidents of wandering and exit seeking, from the same day as her admission through 8/15/25, which was when the admission MDS assessment was completed. There was a total of 63 additional entries noted through 11/14/25, which was when the Quarterly MDS assessment was completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interviews and record reviews, the facility failed to ensure a care plan contained dementia-related interventions, other than nonspecific redirection strategies, for a resident who displayed aggressive behaviors, wandering, had frequent falls, pain, and was an elopement risk, for 1 (#15); and the lack of activities affected 2 others (#s 19 and 20) of 24 sampled residents. This deficient practice resulted in the staff lacking clear guidance on how to effectively meet a resident's needs, placing the resident at risk for inconsistent and unsafe care and unmet psychosocial needs. Findings include:During an interview on 12/15/25 at 3:26 p.m., NF3 stated, I told them she liked crossword puzzles and reading books, but I never saw anyone do activities with her, or anyone that lives there (in the locked memory care unit) for that matter. During an interview on 12/16/25 at 11:31 a.m., staff member C stated he was involved regularly with the interdisciplinary team meetings and risk management meetings. Staff member C stated, I knew of resident #15's aggressions towards other residents and falls but did not know she constantly wandered. Staff member C stated that if he knew of all of resident #15's dementia related behaviors, he would have added more interventions to the care plan, other than just redirecting as needed. Review of resident #15's Care Plan, in her electronic medical record, as of 12/15/25, did not show dementia-related person-centered interventions until three months after the resident's admission to the facility. The resident was admitted in August 2025, and the following intervention was added on 11/4/25: [Resident #15] will have a special door hanger with trinkets and things to distract other resident from going in her room. [Resident #15] is private and doesn't like others going into her room. [sic]Resident #15's comprehensive care plan also included: -A problem was initiated on 8/18/25 related to a cognitive decline. The goal included the resident will develop skills to cope with cognitive decline and maintain safety by the review date. This goal, due to the resident's level of cognitive impairment, was not realistic. The interventions showed staff were to cue and reorient her as needed, but it did not show how they were to do that specifically. The staff were to ask the resident yes and no questions, to determine her needs, and present one thought, idea, or question at a time. There were no other interventions noted on the cognitive decline care plan related to how she was to develop skills to cope with the cognitive decline. - A problem was implemented for an ADL decline on 8/12/25, which included the wording, pain in right knee. None of the interventions addressed the pain in the knee; they all pertained to her personal care and or activities of daily living. - On 8/18/25, a PAIN care plan was initiated for a surgical incision, arthritis, hip fracture, sleep concerns, agitation, delirium, and day-to-day activities. The goal was not to have an interruption of normal activities due to pain. The goal did not show how pain could disrupt the resident, or where pain was located, the type and or severity of pain, or how staff were to monitor it. The plan did not identify or show information about her baseline level of pain, the location(s), severity or type.-A problem for the resident showed she was having limited physical mobility r/t dementia and forgetful which included a goal that showed the resident would demonstrate the appropriate use of non-skid shoes for ambulation, although she had severe cognitive deficits, and her medical record showed she had poor safety awareness. -The elopement care plan was initiated on 8/12/25, showing she was identified as an elopement risk on admission. The interventions showed staff were to offer the activities she preferred, but there were none listed. There were interventions, such as offering structured activities, food, conversation, TV, or a book, but these were interventions used universally for the residents. It was also identified during the survey that there was a lack of activities in the memory care unit. (Refer to F679 Activities of Interest) On the care plan, it showed staff were to identify her patterns of wandering, if it was purposeful, aimless, or escapist, whether she was looking for something, or she was trying to indicate a need. These patterns were not identified or available, per the medical record, as to develop interventions for prevention. -The behavior care plan showed the resident was aggressive to another resident, which was initiated on 9/8/25. The goal was for her to demonstrate effective coping skills, but the resident has severe cognitive deficits and poor safety awareness. The first intervention showed staff were to anticipate her needs, such as food, thirst, toileting, comfort, body position, or pain, but the facility did not identify specifics related to these areas, such as when she frequented the bathroom, where her pain was located, or ways to provide interventions for that specific area of pain during her care or daily routine. Staff were to provide verbal cues, provide positive feedback, encourage her to seek out a staff member when agitated, and assist her in setting goals for more pleasant behavior. On 10/9/25, frequent checks were added for agitated behavior, but the frequency was not measurable or specified. The last intervention, dated 9/8/25, showed she wandered into other resident

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observations, interviews, and record review, the facility failed to provide an ongoing program of daily, individualized or group activities, and meaningful engagement consistent with the cognitive needs and interests of residents with dementia residing on the secure memory care unit. to include for 3 (#s 15, 19, and 20) residents, for those sampled on the secure unit. Findings include:During an observation on 12/15/25 at 2:33 p.m., several residents were sitting in the common room of the secured memory care unit. The common room was noted to be quiet, and no music, movies, or television shows were playing on the TV. There were no interactive, engaging activities or conversations occurring with any of the residents.During an interview on 12/15/25 at 3:26 p.m., NF3 stated, I never saw any activities going on with my mom or anyone when I would go to visit on the weekends.During an interview on 12/16/25 at 10:52 a.m., staff member H stated she worked on the secured memory care unit frequently and said there were no consistent activities for the residents, then stated, Sometimes not at all. Sometimes they ask a CNA to do them, but there is never any time.During an interview on 12/16/25 at 11:17 a.m., staff member L stated, My biggest concern working in the locked memory care unit is that they don't have daily activities for the residents. Staff member L stated, Activities are a huge part of redirecting dementia residents and keeping people safe, but the non-existent activities here is the saddest thing.During an interview on 12/16/25 at 11:38 a.m., staff member E stated, I used to ask why no one was ever down here (in the locked memory care unit) doing activities with the residents.During an interview on 12/17/25 at 9:52 a.m., NF1 stated he had not seen any activities occurring in the memory care unit, then stated, Most of the time they (residents) are just sitting there.During an interview on 12/17/25 at 9:59 a.m., NF4 stated, I have never once observed activities in the common room (in the memory care unit) since my [family member] was admitted there several months ago, and up until the weather turned cold recently, I would visit regularly.During an interview on 12/17/25 at 11:04 a.m., staff member D stated activities (for the facility) were planned six days a week, but not on Sundays. Staff member D stated that most of the activities were located outside of the secure memory care unit.A request was made for documentation regarding the activity participation of three residents who resided on the secure memory care unit, for residents #15, 19, and 20, but no documentation was provided by the end of the survey.Review of a facility policy, titled Activities, with an implementation date of 4/11/25, reflected the following: .9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs.Review of a facility policy, titled Dementia Care, with an implementation date of 4/11/25, reflected the following: . It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interviews and record reviews, the facility failed to provide enough supervision and monitoring of a resident who had a history of falls with injury. The resident resided on the memory care unit, had dementia, and significant cognitive deficits, which hindered her ability to comprehend safety awareness. The resident wandered consistently and had altercations with other residents, and although supervision was in place, it did not meet the resident's safety needs related to her behavior and falls. The resident sustained two major injuries, one was from a known fall, and one was an unknown injury, suspected to be from a fall. The resident's care plan, although it had interventions in place, was not adequate to meet her safety, supervision, and oversight needs related to accidents and hazards, for 1 (#15) of 24 sampled residents. The two major injuries included a compression fracture and a fractured hip, which required surgical repair. Findings include:A review of resident #15's admission Minimum Data Set assessment, with an Assessment Reference Date of 8/13/25, showed the Brief Interview of Mental Status (BIMS) assessment was coded with a score of 00 which was for severe cognitive impairment. The resident displayed inattention and disorganized thinking, which was continuous. The staff stated she had Non-verbal sounds of pain signs or symptoms, for possible pain which was 1 to 2 days of the assessment period. Section J for Falls, showed the coding for falls that occurred before the resident's admission, which included: -Did the resident have a fall at any time in the last month prior to admission/entry or reentry? (J1700A) 1 - Yes, was marked. -Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? (J1700B) 1- Yes, was marked. -Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry? (J1700C) 1- Yes, was marked. Due to the resident's fall history, a thorough fall care plan for fall prevention on admission, and after, would be beneficial for the resident's safety. A review of resident #15's comprehensive care plan showed: -A problem was initiated on 8/18/25 related to a cognitive decline. The goal included the resident will develop skills to cope with cognitive decline and maintain safety by the review date. This goal, due to the resident's level of cognitive impairment, was not realistic. The interventions showed staff were to cue and reorient her as needed, determine her needs, and ask one question at a time. - A problem was implemented for an ADL decline on 8/12/25, which included the wording, pain in right knee. None of the interventions addressed the pain in the knee; they all pertained to her personal care and or activities of daily living. It was unclear if the pain in the resident's knee hindered her ability to ambulate or move safely. - On 8/18/25, a PAIN care plan was initiated for a surgical incision, arthritis, hip fracture, sleep concerns, agitation, delirium, and day-to-day activities. The goal was not to have an interruption of normal activities due to pain. The goal did not show how pain could disrupt the resident and her daily routine(s), mobility, or safety related to accidents and hazards. -A problem for the resident showed she was having limited physical mobility r/t dementia and (was) forgetful which included a goal that showed the resident would demonstrate the appropriate use of non-skid shoes for ambulation, even though she had severe cognitive deficits. The resident's inability to understand safety risks was documented in several areas of her medical record. -The elopement care plan was initiated on 8/12/25, showing she was identified as an elopement risk on admission. The interventions showed staff were to offer the activities she preferred, but none were listed. It was also identified during the survey that there was a lack of activities in the memory care unit. (Refer to F679 Activities of Interest) On the care plan, it showed staff were to identify her patterns of wandering, if it was purposeful, aimless, or escapist, whether she was looking for something, or she was trying to indicate a need. These patterns were not found to have been developed or identified per the medical record, in an attempt to prevent accidents or hazards. -The behavior care plan showed the resident was aggressive and the first intervention showed staff were to anticipate her needs, such as food, thirst, toileting, comfort, body position, or pain, but the facility did not identify specifics related to these areas, such as when she frequented the bathroom, where her pain was typically located, or how staff could alter it using non medicinal or medicinal interventions. The last intervention, dated 9/8/25, showed she wandered into other resident rooms, which increased her risk of conflicts and or accidents/hazards, but there were no specific interventions added for safety related to this. -On 8/12/25, the facility implemented a FALLS care plan, which showed resident #15 was at risk for falls related to her medications and health conditions, behavior, cognition, and poor hearing. The fall care plan did not address her weakness, confusion, intruding on others' spaces, or poor safety awareness. The care plan did not address the psychological evaluation interventions, such as creating a path for her to wander safely without intruding on others. The goal showed the resident would be free of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275025	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalispell Rehabilitation and Nursing LLC	171 Heritage Way Kalispell, MT 59901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility and staff failed to provide the supervision and oversight for a resident residing on the memory care unit, who had dementia, poor safety awareness, displayed aggressive behavior towards others, and would wander continuously. On one occasion, the resident went into a room of a fellow resident, was pushed, had a fall, and fractured her hip, as staff were not available and present to stop her from going into the room, for 1 (#15) of 3 residents sampled on the memory care unit; and, this affected 1 (#20) when resident #15 went into her room and punched her in the chest while sleeping, which made the resident afraid. Although the facility did attempt to identify and implement interventions for the resident and her behaviors, they were not adequate to meet the resident's needs. Findings include: A review of resident #15's admission Minimum Data Set assessment, with an Assessment Reference Date of 8/13/25, showed the Brief Interview of Mental Status (BIMS) assessment was coded with a score of 00 which was for severe cognitive impairment. The resident displayed inattention and disorganized thinking, which was continuous. She was coded as being down, depressed, or feeling hopeless, 2 to 6 days of the assessment period. The resident was always incontinent of bowel and bladder, but did not have a program for bowel or bladder training. The resident was unable to state if she had pain, but the staff stated she had, Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning) of pain signs or symptoms, and this was for the frequency with which resident complains or shows evidence of pain or possible pain which was 1 to 2 days of the assessment period. Section J showed the resident was at risk for falls, and she had prior elopements from home prior to her admission. A review of resident #15's interdisciplinary (IDT) progress notes showed the resident was admitted to the facility on [DATE], and began displaying behaviors the following day. Her IDT notes included: -8/14/25, the resident tried to hit the staff three times, was wandering, up and out of bed consistently, and went into other resident rooms. -8/16/25, resident #15 was combative with care, displayed anxiety and agitation, was restless, and was going into the rooms of other residents. -8/17/25 to 8/24/25, the resident's behaviors continued. On 8/26/25, she attempted to bite a person but was unsuccessful. As of 8/31/25, she complained of hip pain, but did not have any falls. Resident #15 was ordered Tylenol as needed. It was unclear if her pain was a contributing factor to her behaviors and wandering prior to this. -9/5/25, the resident was documented to be going in and out of all the rooms on the memory care unit. She was stealing items from other residents who were complaining about her. Staff noted she usually left her room to toilet, but per review of the MDS, and progress notes, the resident was not on a toileting plan. -9/7/25, resident #15 went into a resident's room, and resident #15 swung at the other resident. She continued her exit seeking, and the progress notes showed she was constantly on the move, I mean constantly. The family member was contacted, and the nurse requested the family member come in to stay with the resident. On 9/8/25, the physician documented the resident had lost weight, which was also documented in the nutrition note dated 9/20/25. One contributing factor to the loss was resident #15's inability to sit still and eat a meal. On 9/27/25, the resident had a fall, trying to sit down in an unlocked wheelchair. She had poor safety awareness per the progress note entries. -10/1/25, resident #15 had another fall, she was brought to the day room by a CNA. It was unclear what she was doing or how the resident got on the floor, due to the lack of staff oversight. On 10/2/25, the progress notes showed the resident needed close monitoring, which was essential, and she was scaring other residents. On 10/4/25, she was again found on the floor, her mattress and blankets half off the bed, and urine was on the floor. It is unclear if the resident's needs were met prior to being found on the floor, or if staff oversight was in place as required. Refer to F689 - Accidents and Hazards for more fall information. -10/8/25, resident #15 went into resident #20's, and while she was in bed, resident #15 punched her in the chest. This caused resident #20 to be afraid of #15. She was also going through the drawers in the room. Per the progress notes, resident #15 was put on 15-minute checks and 1 to 1 observation.-10/9/25, the interdisciplinary team documented the resident willfully places herself on the floor, which was to address the 10/4/25 fall, where she was found on the floor. The facility IDT notes do not show that this behavior occurred. On 10/9/25, it was noted in the nursing progress notes that resident #15 was sitting at the same dining table as resident #20, although #20 previously mentioned fear of #15. Staff did not ensure the two were kept separate. On 10/12/25, 15-minute checks were implemented for behavior monitoring. A review of the monitoring showed it was attempted to be completed on 10/8/25, 10/9/25, and 10/10/25. Of the three pages of 15-minute checks for resident #15