STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275030	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Transitional Care and Rehabilitation	1500 32nd St S Great Falls, MT 59405

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the environment remained free of accidents and hazards, failed to provide supervision necessary to prevent accidents related to falls, and failed to thoroughly investigate (including interviewing resident #129) and identify the direct root causes of falls for future fall prevention, for 4 (#s 5, 45, 156, and 160) of 29 sampled residents, and the falls resulted in resident #160 sustaining a hip fracture, resident #45 had a closed head injury, and #156 had a laceration above the eye; and the facility failed to ensure interventions and safety assessments were in place for a resident who was smoking on facility property, and who kept his smoking materials, and the facility reported they were a non-smoking facility, for 1 (#86) of 29 sampled residents. This deficient practice had the potential to place resident #86 or other residents at risk due to unsafe smoking practices and a lack of supervision. Findings include: 1. During an observation on 4/6/26 at 1:33 p.m., resident #160 was lying in bed on top of an air mattress with the bed in a high position. During an observation on 4/7/26 at 9:05 a.m., resident #160 was lying in bed, on top of an air mattress, with the bed in a high position. During an interview on 4/9/26 at 9:19 a.m., staff member L stated resident beds should not be left in a high position due to safety concerns and should only be elevated during care and returned to the low position when care is completed. During an observation and interview on 4/9/26 at 10:40 a.m., resident #160 was lying in bed on top of an air mattress; the bed was in the lowest position. Resident #160 stated that a couple of weeks ago, she fell out of bed because she had been repositioned too close to the edge of the bed, and the bed was high in the air. Resident #160 stated she sustained a hip fracture from the fall and spent three days in the hospital. Resident #160 stated she was quadriplegic and was dependent on staff for care. Review of the incident report and root cause analysis dated 3/27/26 at 6:40 a.m., showed staff identified the bed too high/low contributed to the fall. Review of resident #160's Interdisciplinary Team Risk Management Follow up, notes dated 3/27/26 at 2:20 p.m., showed: . Root Cause: resident fell out of bed onto the floor, . New interventions: resident placed on fall program; staff education on bed positioning . There was no documentation in the medical record of a fall program or implementation of other (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275030	A. Building B. Wing	04/09/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	interventions for safety related to falls, and the resident's bed remained in a high position. 2. During an observation and interview on 4/6/26 at 2:45 p.m., resident #45 was lying in bed, and his bed was in a high position. Resident #45 had a bruise noted on his left forehead and eye area. The bruise was yellow and light green around the edges, with a lighter brown color near the forehead and eye. Resident #45 stated he sustained the bruise from his fall back in February. Resident #45 stated he was taken to the hospital for an evaluation at the time of the fall. During an observation on 4/8/26 at 10:03 a.m., resident #45 was lying in bed, and the bed was again in a high position. Review of resident #45's emergency room note dated 2/9/26 showed a diagnosis of a fall and a closed head injury; no fractures were noted. Review of resident #45's fall assessment dated [DATE] showed the resident scored a 35, a moderate risk for falls. During an interview on 4/9/26 at 2:10 p.m., staff member C stated it was the resident's preference to have the bed in a high position. Review of resident #45's Interdisciplinary Team Risk Management Follow-up, notes dated 2/9/26 at 4:15 p.m., showed: . Root Cause: resident fell out of bed . New interventions: PT to eval for side rails . [sic] There was no documentation in the medical record of other interventions implemented for safety related to falls for resident #45. 3. Review of resident #5's nursing note, dated 2/4/26, showed: Resident assisted back to bed, bed placed into the lowest position. During an interview on 4/7/26 at 2:11 p.m., NF5 stated resident #5's bed was often way too high when she would visit resident #5. NF5 stated that she was often scared that he might fall out of bed. NF5 stated that the day the facility called to tell her resident #5 fell out of bed, she said, I was so mad. NF5 stated the night nurse called NF5 to report the incident, and stated resident #5 had been leaning out of bed, and the night nurse had been helping another resident when resident #5 had fallen out of bed. NF5 stated she was unsure why a fall mat or bed rails were not utilized for the resident's safety if he was prone to falling out of bed. During an interview on 4/8/26 at 8:47 a.m., staff member T stated a nightshift nurse had not repositioned resident #5 to neutral as they were supposed to because resident #5 naturally shifted to his left side. Staff member T stated, I was quite angry (that resident #5 fell out of bed). Staff member T stated they thought resident #5 could have had a spasm, which could have contributed to his falling out of bed, but staff member T stated if resident #5 had been repositioned properly, he would not have fallen out of bed. Staff member T also stated the facility then got resident #5 a bariatric (wider) bed after the fall. Staff member T stated, Thankfully, he fell on his left side because his right skull is missing. Staff member T stated it was more common sense to reposition him more neutral because he (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	would naturally shift to the left side. Staff member T stated a fall mat and bed rails had been talked about by administrative and facility staff, but nothing was ever implemented before his fall. Staff member T stated a fall mat was not used because of the high number of IV poles around resident #5's bed, and the fall mat had gotten in the way of the equipment. During observations of resident #5 (on 4/7/26 at 9:24 a.m. and 4/8/26 at 8:47 a.m.), no fall mat or bed rails were utilized. Review of resident #5's fall incident report, dated 2/4/26, showed: Resident assisted back to bed, bed placed into the lowest position. resident sent to ER for further evaluation . A request was made for resident #5's fall document to include root causes, IDT notes, the full investigation, interventions, and neuros. The facility provided an interview with resident #5 concerning questions if the resident felt safe and felt comfortable asking for help, but there was no documented attempt to ask the resident what occurred during the fall. No staff interviews were conducted. In the incident report, bed position was shown to be the only predisposing environmental factor. Also, the bed too high/low was shown to be a predisposing factor. The root cause documented on the IDT paperwork showed: resident slid out of bed onto the floor. The intervention implemented after the fall was a bariatric mattress. During an interview on 4/8/26 at 5:04 p.m., staff member C stated resident #5 did not have bed rails because of a concern of safety when the resident had spasms. Staff member C stated the facility was aware of the concern with resident #5 falling out of bed and had tried many interventions, and their resolutions had been working until this point. 4. Review of a staff interview of resident #156's fall on 3/27/26 showed, At around 10:25 a.m. resident's roommate yelled for help . Documentation was requested for the root cause, IDT, full investigation, interventions, neuros for [resident #156] . The documentation received by the facility showed predisposing factors included poor safety awareness. The facility failed to show a root cause, but rather explained the situation as Resident was discovered on the floor, on the left side of the bed. Resident was lying on the left side, head towards the head part of the bed near the bedside table. Resident had her left hand under her head, noted laceration top of left eyebrow. Upon nursing evaluation, EMS notified for resident to be transferred to a higher level of care. [sic] Resident interviews were included concerning if the residents felt safe in the facility, and one staff interview was conducted, which referred to the roommate. The roommate (resident #129) was not interviewed, and the roommate shared with the surveyor that four staff members responded to the incident. The roommate also shared that two hours prior to resident #156's fall, resident #156 showed possible symptoms of a TIA, and there had been a staff member in the room at that time. During an interview on 4/8/26 at 10:18 a.m., resident #129 (the roommate) stated she was getting care from a staff member when resident #156 fell in their room. Resident #129 stated resident #156 had mumbled muuu mu mu jelly two hours before the fall. Resident #129 stated she felt resident #156 had a little TIA. Resident #129 stated she had heard the thump when resident #156 fell. Resident #129 stated she was not asked by facility staff members what happened to resident #156. Review of a facility policy, titled Abuse Investigation and Reporting, revised 7/17, showed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	. d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); . g. Interview staff members (on all shifts) who have contact with the resident during the period of the alleged incident . j. Review all events leading up to the alleged incident. Review of a facility document titled Fall and Fall Risk, Managing, undated, showed: . the staff will identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling and try to minimize the complications from falling. . 11. The facility can use the following interventions, but not limited to these interventions for the resident. Fall matt, 1:1, bed in the lowest position, .placing the resident on a fall program, or other interventions that are resident centered. [sic] 5. During an observation on 4/6/26 at 4:06 p.m., resident #86 left the facility in an electric wheelchair and went around to the back of the facility. Resident #86 was seen by a large blue dumpster and was observed to be smoking. During an observation on 4/7/26 at 10:45 a.m., resident #86 exited the facility in his electric wheelchair and went around to the back of the facility. Resident #86 was seen smoking a cigarette by a large blue dumpster near the back of the facility. During an interview on 4/7/26 at 11:03 a.m., resident #86 stated he was a smoker. Resident #86 stated that when he was admitted to the facility, he signed a form notifying him he could not smoke on the property, but went back by the blue dumpster because no one could see him there. Resident #86 stated he kept his cigarettes and lighter either on him or in his room. Resident #86 stated he did not sign out every time he left the facility, and stated he only signed out if he was going out with family or to the grocery store. Resident #86 stated the facility was aware he was smoking and told him he had to smoke off the property. During an observation on 4/7/26 at 1:37 p.m. and 4:05 p.m., resident #86 was smoking by the blue dumpster. During an interview on 4/7/26 at 4:15 p.m., staff member F stated residents were to sign out when they were leaving the facility or the property. During an observation on 4/8/26 at 9:25 a.m. and 10:30 a.m., resident #86 was smoking by the blue dumpster. Review of resident #86's resident sign-out log showed the last entry was on 3/30/26 at 12:45 p.m. During an interview on 4/8/26 at 3:18 p.m., staff member A stated the facility was a non-smoking facility, and resident #86 signed the acknowledgement upon admission. During multiple observations throughout the duration of the survey, resident #86 was observed leaving (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the facility unattended, smoking on facility property by a dumpster, and not signing out or back in when he returned. Facility staff were unaware of when the resident was outside smoking on facility property or when he left the facility. Review of resident #86's physician's orders dated 10/2025 - 4/9/26 showed no orders for smoking or smoking cessation options. Review of resident #86's comprehensive care plan showed no focus, goals, or interventions for smoking. Review of resident #86's admission or quarterly evaluations completed by nursing staff showed no completed assessments or evaluations related to smoking safety. Review of a facility policy titled Smoke Free Facility, undated, showed: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees. Therefore, this facility is a Smoke Free Facility. - This policy applies to all residents residing in the facility. - Smoking is prohibited in all areas of the facility. - Residents will be informed of the facility's Smoke Free Policy. and will be required to sign an acknowledgement of the policy upon admission. . 5. Residents with a history of smoking will be further assessed to determine whether or not interventions are needed . 6. Residents who smoke will be offered supportive materials regarding smoking cessation. . 8. Residents that are found smoking on facility grounds could be subject to discharge. Review of a facility policy titled, Resident sign out policy, undated, showed: . 2. Residents (or their representatives) must notify the unit nurse or charge nurse for short outings. . 4. All sign-outs and leaves of absence will be documented on the facility Sign-Out Logs, which includes resident name, date/time out, and signatures. [sic]

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	275030	A. Building B. Wing	04/09/2026

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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 dietary staff in the kitchen preparing and serving food during meal service wore beard coverings, and failed to ensure kitchen refrigeration temperature logs were monitored and maintained. This deficient practice increased the risk for residents receiving food and meals which were prepared, served, and stored in the kitchen to experience negative food service safety outcomes. Findings include:During an observation on 4/6/26 at 1:02 p.m., staff member Y was preparing sandwiches in the kitchen, not wearing a beard net with visible facial hair.During an observation on 4/6/26 at 1:14 p.m., staff member X was in the kitchen serving food onto resident trays from behind a steam table. Staff member X did not have a beard net covering his facial hair.During an interview on 4/8/26 at 2:18 p.m., staff member W stated dietary staff working in the kitchen were expected to wear facial coverings if they had a grown beard or mustache. Staff member W stated she spoke with staff members X and Y about wearing a covering over their facial hair while working in the kitchen, after the surveyor observed them not wearing the facial coverings. Staff member W stated that staff members X and Y agreed to wear beard nets instead of shaving their facial hair. Staff member W stated she kept logs of daily refrigerator and freezer temperatures, which were monitored each month. Staff member W stated she did not know why two of the daily logs for refrigerators in the kitchen did not have any temperatures written for a couple of weeks in March (2026). Staff member W stated she thought the temperature logs had gotten misplaced somewhere. Review of a facility document titled Daily Freezer/Refrigerator Temperature Log, dated March (2026), showed that refrigerator R1 had a note of Lost these ones in the section for days 1-15. There were no twice-daily temperature checks written on the log for days 1-15.Review of a facility document titled Daily Freezer/Refrigerator Temperature Log, dated March 2026, showed that refrigerator R4 had a note of Lost these ones in the section for days 1-15. There were no twice-daily temperature checks written on the log for days 1-15.Review of a facility policy titled Dietary Employee Personal Hygiene, undated, showed: . It is the policy of this facility to utilize the following as guidelines for employee personal hygiene to prevent contamination of food by foodservice employees. 4. Hair Restraintsa. All dietary staff must wear hair restraints (e.g., beard restraint) to prevent hair from contacting food.Review of a facility policy titled Monitoring of Cooler/Freezer Temperature, undated, showed: . It is the policy of this facility to maintain temperatures of coolers and freezers at the appropriate temperature to promote food safety. This policy also addresses refrigerated storage. 1. Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit.a. Temperatures will be checked and logged at least twice per day by designated personnel.3. All refrigerated storage must be maintained at or below 41 F, unless otherwise specified by law.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure professional standards were followed by protecting patient health information from visitors for 3 (#s 79, 121, and 134) of 29 sampled residents and failed to ensure medication carts were locked when unattended. Findings include: 1. During an observation on 4/6/26 at 4:27 p.m., the medication cart on the 100 hall was not locked. No staff member was present at this time.During an observation and interview on 4/8/26 at 8:32 a.m., staff member Z left the medication cart open after medications were prepared for a resident and staff member Z entered the resident's room to administer the medications. After returning to the hallway, staff member Z stated the medication cart should always be locked to ensure a visitor or resident could not take medications in the cart. Staff member Z also stated the medication keys should be in her pockets at all times to prevent a visitor or resident from getting into a medication cart or rooms. Staff member Z stated the medication cart should always be locked if she was not near the cart and this was a skill that she learned in her training at school. Staff member Z stated this was not a skill that the facility provided, but was an overall expectation of all nurses, medication techs, or anyone administering medications.2. During an observation on 4/8/26 at 8:41 a.m., the computer monitor on hall 500 was unattended and patient information was clearly viewable.During an observation on 4/8/26 at 8:41 a.m., there were four boxes with patient information on the 500 hall medication cart without a staff member present.During an interview on 4/8/26 at 8:47 a.m., staff member T stated the four boxes (fluticasone for resident #134, diclofenac gel for resident #79, calcitonin spray for resident #121, and formoterol spray for resident #121) were to be disposed of, but staff member T had not gotten time to do this yet. Staff member T stated patient information should not be out for any visitors to see.During an interview on 4/8/26 at 5:04 p.m., staff member C stated patient health information should not be easily accessible to visitors. Staff member C also stated medication carts should be locked at all times when a staff member was not present and the medication keys should never be located on top of the carts.Review of a facility policy, titled Medication Storage, no date, showed: . All drugs and biologicals will be stored in locked compartments .

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	275030	A. Building B. Wing	04/09/2026

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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. Based on interview and record review, the facility failed to ensure accurate coding of medications on the Minimum Data Set (MDS) in accordance with the Resident Assessment Instrument (RAI) Manual for 1 (#126) of 29 sampled residents. This deficient practice had the potential to affect quality measures, and care planning related to diabetes management. Findings include:Review of resident #126's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/23/26, showed under Section N (Medications), item N300 (number of injections received in the last 7 days) was coded as 7, and item N350 (number of days insulin injections were received) was coded as 7.Review of resident #126's physician's orders, dated 1/23/26, showed, Victoza Subcutaneous Solution Pen-injector 18 MG/ML (Liraglutide) Inject 0.6 mg subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS. [sic] Victoza is a GLP-1(Glucagon Like Peptide-1), which is a hormone that is used for weight loss and diabetes and is not considered insulin.During an interview on 4/9/26 at 11:12 a.m., staff member F stated she was responsible for completing section N of the MDS and recognized she coded Victoza as insulin because the diagnosis on the order was for Diabetes Mellitus Type II, but did not verify the medication class. Staff member F stated she had training on MDS completion and was familiar with the RAI Manual.Review of the MDS 3.0 RAI Manual, with a revision date of 10/2025, Chapter 3, Section N, showed: . 1. Review the resident's medication administration record for the 7-day look back period.2. Determine if the resident received insulin injections in the look back period.

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	275030	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Transitional Care and Rehabilitation	1500 32nd St S Great Falls, MT 59405

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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 include interventions related to catheter care on the care plan for 1 (#6) of 29 sampled residents. Findings include:During an observation and interview on 4/7/26 at 11:37 a.m., resident #6 was sitting in her wheelchair in her room and an indwelling catheter tube was coming out of the bottom of her pajama pants. NF3 stated the facility was continuing catheter use for resident #6 due to incontinence and the resident wanted the catheter due to convenience.During an interview on 4/9/26 at 9:25 a.m., staff member D stated catheter interventions should be on a resident's care plan.Review of resident #6's care plan, dated 3/11/26, reflected a lack of catheter care interventions.

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	275030	A. Building B. Wing	04/09/2026

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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. Based on interview and record review, the facility staff failed to review and revise the comprehensive care plan to reflect changes in resident conditions for 1 (#91) of 29 sampled residents. This deficient practice increased the risk of staff not monitoring or providing cares related to resident #91's treatment for pneumonia with an antibiotic. Findings include:During an interview on 4/9/26 at 11:09 a.m., staff member N stated she had a list of residents taking antibiotics used to treat infections. Staff member N stated she would update a resident's care plan with problems and interventions when a resident was identified to have an infection. Staff member N stated resident #91 had enhanced barrier precautions as an intervention in her care plan. Staff member N stated enhanced barrier precautions would cover part of the droplet precautions to use for a resident diagnosed with pneumonia. Review of resident #91's provider progress notes, dated 3/24/26, showed: . Patient experienced 2 episodes of emesis on March 24, 2026, with 4 hours of nasal congestion since this morning. Patient afebrile. Chest x-ray ordered to rule out pneumonia.Review of resident #91's provider progress notes, dated 3/25/26, showed: . Physical examination revealed mild crackles in left lower lobe on exam. Effusion being monitored in context of pneumonia treatment. Will continue supportive care and reassess response to antibiotic therapy.Lobar pneumonia. Chest x-ray obtained March 24, 2026 showed left lower lung infiltrate and/or atelectasis consistent with likely early development of pneumonia. Based on normal renal function and amoxicillin allergy, levofloxacin 500 mg by mouth once daily for 7 days was ordered. [sic]Review of resident #91's comprehensive care plan, revised 1/5/26, showed, - An intervention for Enhanced barrier precautions due to having catheter. Gowns and gloves required for all contact cares, and- A problem of RESPIRATORY: . at risk for respiratory decline and infection related to chronic obstructive pulmonary disease, recent pneumonia infection, history of pulmonary embolism, dysphagia, and multiple sclerosis.Resident #91's care plan failed to include revisions for a problem, goal, or interventions related to antibiotic treatment for pneumonia initiated on 3/25/26 for seven days, and did not include updates to transmission-based precautions to use when caring for resident #91.Review of a facility policy titled Comprehensive Care Plans, revised 4/5/26, showed: . 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. h. Any infection control interventions/guidelines established by the CDC deemed appropriate as indicated by resident condition/status. 9. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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	275030	A. Building B. Wing	04/09/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to complete a reweight with a resident having a 22% weight loss (severe weight loss) after one week for 1 (#72), and failed to complete monthly follow ups with a resident who voiced concern about her consistent low weight for 1 (#110) of 29 sampled residents. Findings include:1. Review of resident #72's EHR showed an initial weight of 207.8 pounds (on 2/10/26). Resident #72's next weight (on 2/22/26) was 170 pounds. This is a 22.2% weight loss in a week.Review of resident #72's Care Plan, revised 2/21/26, showed: . Notify registered dietician and medical provider of weight loss greater than 5 pounds.During an interview on 4/9/26 at 7:50 a.m., staff member BB stated a fifty-pound weight loss in a week was most likely due to an incorrectly obtained weight, such as from equipment.During an observation and interview on 4/9/26 at 7:52 a.m., staff member AA stated resident #72 had come into the facility with a wheelchair from the hospital. Staff member AA stated that those wheelchairs almost always weighed about 50 pounds. Staff member AA stated the process for obtaining a weight was to get the weight with the wheelchair and the resident, then to get the weight of just the wheelchair, so the weight of the resident could be calculated. Staff member AA weighed resident #72's current wheelchair and showed the weight to be 53.1 pounds.2. During an observation and interview on 4/6/26 at 2:22 p.m., resident #110 stated she would like to gain weight and stated her clothes were starting to get too big on her. She stated the facility did not offer her any snacks that she enjoyed. Resident #110 stated the facility offered pudding and Jello, but resident #110 did not consider this to be a snack for her. Resident #110 stated she had her family and friends bring in snacks because she did not like the snacks offered. Resident #110 stated she liked sweet snacks such as ice cream but often stated that by the time the facility delivered the ice cream, it was melted. No snacks were observed at her bedside.During an interview on 4/9/26 at 8:58 a.m., resident #110 stated she was offered snacks a few times, but they were usually late at night (after 9:00 p.m.) when she did not want any and was already asleep.Review of resident #110's EHR showed a nightly snack was offered, but the resident was documented as being unavailable nine out of thirty days. Refer to the dates and times listed below:-3/10/26 at 9:07 p.m.,-3/13/26 at 8:49 p.m.,-3/14/26 at 8:53 p.m.,-3/18/26 at 10:33 p.m.,-3/19/26 at 9:05 p.m.,-3/24/26 at 10:02 p.m.,-3/27/26 at 9:29 p.m.,-4/6/26 at 10:20 p.m., and-4/7/26 at 9:53 p.m.Resident #110's current weight (on 4/7/26) was 77 pounds. From 3/5/25, resident #110's weight had averaged 70 to 80 pounds.A request was made for documentation related to any notes, care plans, etc., related to . [resident #110]'s weight loss. The following was found:Review of resident #110's dietician's note, dated 1/10/26, showed: . Dietician to revisit with her if her weight is down again.Review of resident #110's dietitian's note, dated 4/3/26, showed: . 6.25% weight loss in less than 1 month. There was no dietitian documentation in February or March 2026.During an interview on 4/8/26 at 4:00 p.m., staff member Q stated resident #72 was on the hall that she did not cover, but stated after the large difference between the admission and second weight, there should have been a reweight. Staff member Q stated for resident #110, there should be at least monthly evaluations, notes, or care plan meeting notes because staff member Q was meeting with her that frequently. Staff member Q stated monthly meetings were required for a resident who had weight loss or if weight was a concern. Staff member Q stated resident #110 was a picky eater, and finding foods that she enjoyed was a challenge. Staff member Q stated fortified foods were not implemented for resident #110, as staff member Q stated resident #110 did not want to gain weight. Staff member Q stated resident #110 was on a regular diet and stated the facility did have products such as a high-calorie dense pudding, but resident #110 was not receiving items like this.

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	275030	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Transitional Care and Rehabilitation	1500 32nd St S Great Falls, MT 59405

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations and interview, the facility failed to ensure appropriate and safe PEG tube practices were followed for 1 (#5) of 29 sampled residents. Findings include:During an observation on 4/7/26 at 9:24 a.m., resident #5's PEG tube was unclamped and unhooked from any tubing.During an observation and interview on 4/8/26 at 8:47 a.m., resident #5's PEG tube was unclamped, and still hooked up to the kangaroo pump with the enteral nutrition not running. Staff member T stated the kangaroo pump had been turned off at 6:30 a.m. and the tubing should have been flushed, clamped, and unhooked from the resident. Staff member T looked at resident #5 and stated, She got me there. Staff member T had been referring to the PEG tube being incorrectly still being hooked up and unclamped. Staff member T stated they did not worry about a clogging PEG tube as often with this resident due to the larger circumference of the PEG tubing.According to the University Hospital PEG tube feeding guidelines, a PEG tube should be clamped after being flushed with water (University Hospitals, 2025). References:University Hospitals. (2025, June). PEG Feeding Tube Guide. Retrieved from https://www.uhhospitals.org/-/media/files/services/cancer/patient-education/peg-tube.pdf

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility staff failed to adhere to nationally recognized standards of hand hygiene when passing meal trays for 2 (#s 85 and 92) of 2 supplemental residents sampled for infection control during meals. This deficient practice had an increased risk of transmitting infections to all residents who received meals in the dining room. Findings include:During an observation on 4/8/26 at 12:05 p.m., staff member K obtained a meal tray from the kitchen and placed it on a dining room table without performing hand hygiene. Staff member K removed the plate cover and left the area. Staff member K walked back to the kitchen and obtained another meal tray and delivered it to resident #85 without performing hand hygiene.Staff member K walked over to resident #92 and grasped the wheelchair handles and pushed her to the dining room table where the uncovered meal tray had been placed and proceeded to handle resident #92's silverware without performing hand hygiene between contact with the wheelchair and the meal tray items.During an interview on 4/8/26 at 12:20 p.m., staff member K stated he was a new employee and had been educated on hand hygiene prior to starting his first shift. Staff member K stated he should have completed hand hygiene between residents and meal trays.Review of a facility document titled, Hand Hygiene, undated, showed: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.1. Staff will perform hand hygiene when, indicated, using proper technique consistent with accepted standards of practice.2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. [sic]Review of a facility document titled, Hand Hygiene Table, undated, showed:In the column under Condition showed . Between resident contacts, . After handling contaminated objects and . when in doubt. an X was placed showing Either Soap and Water or Alcohol Based Hand Rub.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	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. Based on observation, interview, and record review, the facility failed to ensure a system was in place, so grievance forms were readily accessible without staff needing to assist in the provision or acceptance of a grievance form, and that grievances received were secured to maintain confidentiality. The deficient practice was widespread and may affect any resident, family member, or visitor who wishes to complete and or submit grievances without staff assistance or maintain confidentiality. Findings include:During an observation on 4/7/26 at 9:10 a.m., the door to the social services office was closed, and residents and staff members were passing through the hallways near it. A wall-mounted file holder was located on the wall outside the door to social services. Grievance forms were inside the holder, with writing and completed forms that showed resident names and information. The folder holding the completed forms was not secured to maintain confidentiality. During an observation on 4/8/26 at 10:18 a.m., residents and staff members on the 400 unit were moving through the common area near the nurses' station and down hallways. There was no visible holder or signage for grievance forms on any walls or throughout the unit.During an observation and interview on 4/9/26 at 10:51 a.m., staff member R was sitting with another staff member at the nurses' station at the end of the 200 unit. Staff member R stated residents would have to ask staff for a grievance form to fill out. Staff member R stated that grievances were kept in a desk at the nurses' station. Staff member R stated if a resident had a question about a grievance, they could be directed to the social services office at the end of the unit. There were no grievance forms readily available on the unit for residents to access without staff having to assist. During an observation and interview on 4/9/26 at 11:08 a.m., staff members S and T were sitting at the nurses' station on the 500 unit. Multiple staff members were present and walked through the hallways of the unit. There were no visible holders or signs for grievances in the unit. Staff member T stated she would look to see where grievance forms were when asked for one. Staff member T looked through some drawers of a desk at the nurses' station to find forms. Staff member S stated residents on the 500 unit could bring grievances to the drop box outside of social services. Staff member S stated if residents could not get to the social services office, staff could bring their grievances down to drop them off for them. During an interview on 4/9/26 at 11:34 a.m., with staff members A and V, staff member V stated he was the grievance official for the facility. Staff member V stated residents could fill out grievances, or staff could assist them. Staff member V stated that residents could verbally give information for grievances to be filled out. Staff member V stated residents could put completed grievances in the box on the wall outside of his office (which was not secured for confidentiality). Staff member V stated residents could also push grievance forms through the bottom opening of the door on the floor to the social services office. Staff member A stated that the box on the wall outside the social services office was not locked. Staff member A stated the facility did not have any locked drop boxes for grievances in the building.Review of a facility document titled Resident and Family Grievances, not dated, showed: . It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal, or fear of discrimination or reprisal. 2. Social Services Department is responsible for . maintaining the confidentiality of all information associated with grievances. 7. Information on how to file a grievance or complaint will be readily available throughout facility. 9. A grievance may be filed anonymously.10. Procedure:. iii. All staff involved in the grievance investigation or resolution will take steps to preserve the confidentiality of files and records relating to grievances . [sic]

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure current, readily available results of surveys completed by the State Survey Agency were located in a publicly accessible area. This deficient practice increased the risk of residents to be uninformed of oversight agency findings as required by the rights of long-term care residents. Findings include:During an observation and interview on 4/8/26 at 11:22 a.m., a wall-mounted file holder labeled Survey Results was located by the entrance of the building near the reception desk. The holder had a binder with documents inside that contained State Survey Agency survey reports. The binder failed to include a report for the 2025 recertification survey. Staff member N walked towards the hallway next to the wall where the survey results binder was located. Staff member N stated she would check to see why last year's survey results were not in the binder.During an interview on 4/9/26 at 11:43 a.m., staff member A stated she did not know why the survey results binder did not include survey results from last year. Staff member A stated she was not sure why the survey report and plan of correction for 2025 had been removed. Staff member A stated she usually checked the binder closer to annual survey time, maybe two weeks before the time of the survey, to see that results were there. Staff member A stated the same thing happened last year during the annual survey.Review of a facility document titled Resident Rights, not dated, showed: . 6. Information and Communication. k. The resident has a right to:i. Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.