STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275044	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Ascension Transitional Care of Cascadia	2475 Winne Ave Helena, MT 59601

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interview, and record review, the facility failed to ensure staff received facility specific restraint and abuse prevention training prior to providing resident care to keep a resident free from a physical restraints for 1 (#3) of 9 sampled residents. This deficient practice resulted in the resident biting at the placed hand restraints causing their tooth to break. The deficient practice increased the risk of imminent harm related to restraints. The facility identified the failure of staff utilizing physical restraints and addressed and corrected the deficient practice before the survey, resulting in the findings of past non-compliance. Findings include:Review of a facility reported incident, submitted to the State Survey Agency on 12/28/25 at 6:00 a.m., showed, [Staff member D] restrained our resident [resident #3] . [Employee title] was sent home. [Resident #3] is safe and is being sent to the hospital for a head-to-toe examination. Full investigation to follow.Review of the facility reported incident's investigative findings, submitted to the State Survey Agency 1/2/26, showed, . [Staff member D] allegedly attempted to restrain [Resident #3] while trying to protect her from harming herself . Investigation & Conclusion: On December 28th, 2025, a report was made regarding the care that [Staff member D], was providing for [Resident #3]. It was reported to the Administrator that [Resident #3] was seen digging at her ostomy site and cutting her skin in the process. Upon observing this, [Staff member D] attempted to use washcloths and pillowcases around her hand to prevent her from digging further at her ostomy site at the time of the shift change . Upon entering the room, [Staff member E] observed one of [Resident #3's] hands wrapped with the washcloths and the [Staff member D] attempting to wrap her other hand. [Staff member E] stopped the process and asked the nurse to leave the room while he tended to [Resident #3's] care and removed the washcloths from her hand . [Staff member A] asked him (staff member D) to explain what happened. He stated that [Resident #3] was very anxious, agitated, and began digging at her surgical wound on her hip and was digging at her stoma and sticking her fingers in it. [Staff member D] reported that this caused (the resident) her to bleed from her stoma . [Staff member D] stated that he planned to give resident #3 her [as needed] anxiety and pain meds in an attempt to calm her down. He administered Lorazepam 0.5 ml at [5:21 a.m.] and morphine sulfate 0.25 ml at [5:20 a.m.]. He stated that he waited 15-20 minutes and reassessed her. It was at this time that she was still digging at her surgical site and her stoma. [Staff member D] stated it was at this time that he became further concerned for her safety and thought that protecting her from her hands would be an appropriate next step. He stated that he went to [Resident #3's] room and began to wrap the washcloths and pillowcases around her (#3's) hands. He stated that the first hand was protected and was in the middle of the second one when [Staff member E] entered the room and asked him what was going on. [Staff member D] stated that he tried to explain that he was trying to protect [Resident #3], but [Staff member E] informed him that what he was doing can be considered a restraint and is not allowed in our setting (long term care) . [Staff member D] responded with Oh and further stated that he didn't know what else to do because (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
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she wouldn't stop digging at her stoma . [Staff member E] also stated that [Resident #3] bit at her wrapped left hand, and while doing so, she cracked one of her teeth . An interview (with) [staff member G] . stated that [Resident #3] was agitated and digging at her stoma. She stated that [Resident #3] had dug so much that her stoma (it) began to bleed . she informed the nurse that she was doing so, and he gave her some medications to help calm her down. Shortly after the meds were given, [Staff member G] noticed that [Resident #3] had removed all her clothes and was continuing to dig at her stoma. She informed the [Staff member D] and he told her that he wanted her to assist in keeping her from digging at her stoma. She stated that she told [Staff member E] what was going on when he arrived and [Staff member E] immediately went to intervene . Based upon the investigation conducted by the facility, staff interviews, resident interviews, and observations, it was confirmed that . This appears to be an incident where a well-intentioned [Staff member D], that was trying to protect a patient from harming themselves, tried to implement an intervention that was not appropriate for this setting and was immediately interrupted by [Staff member E] who intervened on the implementation of the intervention . The facility documented the plan to prevent a recurrence of the events related to the restraint implementation. A review of staff members D, I, K, personnel files, on 1/7/26, failed to show restraint and abuse prevention training was completed by the facility prior to providing resident care for the facility on or before the incident on 12/28/25.During an interview on 1/6/26 at 3:45 p.m., staff member C stated they had identified training of travel agency staff of the facility's restraint prevention protocols as an area that required corrective action by the facility. She stated it had since been implemented.Review of the facility's Performance Improvement Plan, Past Non-Compliance, dated 12/28/25, showed, Facility identified that an agency staff member had failed to follow facility policy for restraints. Review of facility Restraint and abuse policies. Review of facility onboarding content for new hire and agency staff. List of corrective actions for resident(s) affected: -Re-education of all staff on abuse and restraint policies. -[Human Resources] to receive education on importance of ensuring all new hires have abuse and restraint training prior to their first shift on the floor. -Staffing coordinator to receive education on the importance of ensuring all agency staff have abuse and restraint training prior to their first shift on the floor.Identification of others at risk: Staff interviews/education for understanding of abuse and restraints. -Random resident interviews for concerns about restraints. Objective measures to evaluate plan effectiveness: -Validate that all new hire and agency staff have abuse and restraint training upon hire prior to first shift on the floor. -Random interviews with staff to ensure that they understand the abuse and restraint policies. System changes: -Abuse and restraint training during the onboarding process needs to be completed prior to first day on the floor. -[Human Resources] and staffing coordinator to verify training is complete prior to assigning first shift on the floor. Training/Education: -All staff will receive abuse and restraint training. -[Human Resources] and staffing coordinator will receive training on new process for abuse and restraint education completion prior to an employee's first shift on the floor. Monitoring: -. will complete random employee file checks to ensure that abuse and restraint training has been complete. Interview of staff to validate compliance: -. will complete random employee interviews to ensure staff understand the abuse and restraint policy. Quality Assurance Program Improvement:-Facility to hold a [Quality Assurance Program Improvement] meeting to address . identify any causal factors, failed systems, and to approve appropriate plan of action for correction and continued compliance . Completion date of 1/6/26. [sic]Review of facility training, titled, abuse types, restraints, reporting rules, dated 1/2/26 and 1/6/26, showed staff were provided education.Review of the facility's policy and procedures, titled Physical Restraints, with a revision (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date of 9/16/25, showed the facility implemented policy and procedures for restraint prevention.The facility immediately identified the concern related to the improper restraint use, immediately protected the resident, and implemented interventions to correct and sustain compliance. Past noncompliance was identified due to the identification of the deficient practice and corrective actions taken by the facility.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a thorough investigation, take corrective action to ensure the safety of a resident with a known elopement attempt, and maintain documentation of the investigation involving the resident who left the protective oversight of the facility when transported to a dental visit, and he was left unattended, and then left the dental office alone and traveled to a relative's house, approximately two miles away. The resident's location was unknown for approximately one hour, for 1 (#2) of 3 sampled residents for wandering and elopement risk. The facility's failure to address these concerns placed this resident at continued risk of harm. Findings include:During an interview on 1/6/26 at 12:00 p.m., NF3 stated resident #2 had a diagnosis of schizophrenia and would have hallucinations of spirits that would tell him to do things. She stated resident #2 was fairly cognitively intact and able to make certain decisions for himself but could exhibit poor and impulsive decision-making which made him vulnerable when left unattended. NF3 stated resident #2 was transported to a dental visit by the facility on 12/16/25. She stated she was not able to make it to the appointment that day. NF3 stated she received a call from the facility informing her the resident had left the dental office unsupervised on 12/16/25. She said when staff member A contacted her inquiring where she thought the resident may have gone, she informed them the resident had expressed his wish to travel to Washington State via a bus to visit friends. She stated she also told the facility that the resident may have returned to a relatives house where he used to live, which was located in town. She stated the resident's whereabouts were unknown for approximately an hour. She then received a phone call from staff member A stating the resident had shown up at the relatives house.Review of resident #2's Appointment Calendar, showed an appointment was scheduled at a dental clinic downtown on 12/16/25 at 2:40 p.m., to 3:40 p.m. A note provided in the description of the appointment showed, [Resident #2] .for dental pain. [in all capitalized letters] Please stay with him elopement risk [end of capitalized letters] sister will be there a few min after 3. [sic]During an interview on 1/6/26 at 9:27 a.m., staff member L stated he transported resident #2 to a dental appointment on 12/16/25, leaving the facility around 2:40 p.m. He stated he was aware the resident was not to be left unsupervised during the visit. He stated NF3 was supposed to be there, but she did not show up for the appointment. He said he waited with the resident until the resident was escorted back to the exam room. He said he believed the resident would be safe while seeing the doctor, so he decided to make a quick trip to pick up some paperwork from another facility. He said when he returned at approximately 4:00 p.m., he was informed by the dental staff that the resident had already left. Staff member L stated he had received training on elopement management and protocols when he started at the facility approximately one year ago.Review of a facility reported incident, dated12/16/25 at 4:00 p.m., showed, Incident Description: [resident #2] was taken to a dentist appointment and refused to come back to the facility. He took a taxi to his [relative's] house where he used to live. The police were called and met him and I at his [relative's] house and were unable to convince him to come back to the facility. His POA was notified and was also unable to convince him to come back to the facility. [Resident #2] has decided to stay at [relative's] house where he used to live for the time being. No injuries noted. He was left by the police and I at his [relative's] house because he was deemed safe for the evening by the police and his POA.Review of the facility reported incident findings, dated 12/22/25, showed, [Resident #2] is a [AGE] year-old long term care resident who admitted to us on 7/31/25 with a diagnosis of Volvulus, schizoaffective disorder, intestinal obstruction, and major depressive disorder. He has a current BIMs of 12 (moderate cognitive impairment). We took [Resident #2] to a dentist appointment and while there (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he decided to call a taxi and leave and go to his [relative's] house where he used to live with her. I immediately called the police and reported it and went to his [relative's] house where I was met by the police and [Resident #2]. [Resident #2] was inside the house and stated that he didn't want to live at [Facility Name] anymore and that he was going to live on his own again. He also expressed the desire to hitchhike or take a bus to [NAME] to visit his friends, even though his sister confirmed with him that they had all passed away years ago or were in prison. He was undeterred by this and insisted that he was going because he didn't believe her. Both the police and I were there for about [1.5] hours talking with [Resident #2] and he ultimately decided that he was not coming back. We had [NF3] on the phone the whole time and she was unable to reason with him either. [NF3] agreed that he could spend the night at [relative's]house because he was safe and she would come visit him in the morning. Both the police and I left. [NF3] said she would come by in the morning and get his things and sign the [Against Medical Advice] paperwork. The next morning [Resident #2 and NF3] arrived at [Facility Name], and [Resident #2] had decided that he had made a mistake and wanted to come back and be a resident here. We agreed to take him back with some stipulations. [Resident #2] agreed to start taking his meds again as well as agreeing that for every appointment he goes on, [NF3] will accompany him. They both agreed and we readmitted [Resident #2]. There have been no further issues with [Resident #2] since his readmission. If the alleged violation(s) was verified, what corrective action has been taken? Not verified for abuse.During an interview and record request on 1/7/26 at 10:40 p.m., staff member C stated there was no IDT review or an after-action plan completed to investigate resident #2's elopement on 12/16/25. She stated it was the facility's expectation that this be completed at the time of an event such as an elopement, and there were established policies and procedures that addressed the process. Staff member C stated they did not have documentation for an IDT review of the incident, an after-action post elopement/wandering evaluation, and no corrective actions were determined.During an interview on 1/7/26 at 10:53 p.m., staff member A stated they did not complete anything other than the facility reported incident. He stated there was an IDT meeting the next day, during which they discussed the events surrounding resident #2's elopement, but they did not have anything documented. He stated since the resident was determined to be safe and wanted to leave against medical advice, they did not complete an after-action plan or complete a full investigation surrounding the resident's elopement, and no corrective actions were determined. He stated that after the resident returned to the facility the next day, they did not complete an investigation into the elopement or determine corrective actions. Staff member A stated they did not document the events that occurred surrounding the time the resident left the dental visit unsupervised and the time the resident was located. He stated the duration of time the resident's location was unknown and unsupervised was approximately one hour from the time he was notified by staff member L to when he found resident #2 at the resident's relatives' house. A review of the facility's policy and procedure titled, Elopement, released 9/16/25, showed, . 8. The Interdisciplinary Team will investigate the incident, identify contributing factors and root cause analysis, and document findings and recommendations in the medical record and plan of care updated as indicated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to modify care plan interventions to reduce the risk of elopement, failed to provide routine behavioral monitoring for a resident with a known elopement risk, failed to provide supervision of a resident with a known elopement risk during transport to a medical appointment which resulted in the resident leaving unsupervised, failed to conduct an interdisciplinary investigation of an elopement, and failed to ensure a resident's care plan interventions were updated to prevent the reoccurrence of an elopement for 1 (#2) of 9 sampled residents. The facility's failure to address these concerns placed this resident at a continued risk of elopement and or harm. Findings include:During an interview on 1/6/26 at 12:00 p.m., NF3 stated resident #2 was fairly cognitively intact and able to make certain decisions for himself, but could exhibit poor and impulsive decision-making which made him vulnerable when he left unattended. She said resident #2 did much better when he took his medications regularly and he would become more irrational and impulsive when he quit taking his medications. She stated the resident started to express a desire to leave the facility to visit friends in Washington State in September 2025. She said he was evaluated by the facility at that time and was determined to be at risk for elopement. She stated they had a care plan meeting where they discussed interventions to prevent him from eloping, which she believed included that he could take walks outside, but he was to be supervised by staff. When he went to doctor visits, he was to be supervised by staff if she (NF3) was not able to attend the appointment. She stated staff were to redirect him when he started to wander more or attempt to leave the facility. She stated she had also expressed a concern back in November 2025, because resident #2 told her he wanted to leave the facility because he was angry with her for putting him in the facility, and he still wanted to visit his friends in Washington State. NF3 could not recall if they made any changes to his care plan at that time. NF3 stated resident #2 was transported to a dental visit by the facility on 12/16/25. She stated she was not able to make it to the appointment, and she received a call from the facility informing her that the resident had left the appointment unsupervised. NF3 stated the facility was aware that resident #2 was not to be left unsupervised during outings. NF3 stated that when staff member A inquired about resident #2's location, she informed him that the resident may have gone to another family member's house, where he used to live, and that he had wanted to travel to Washington State by bus to visit friends. She stated she believed the resident had been planning this elopement for some time. NF3 stated she was notified by staff member A, approximately an hour later, that resident #2 had shown up at the relative's house, and the police were there. She stated the resident would not return to the facility that evening, and the police determined he was safe and therefore could not make him return to the facility. The resident stayed the night at the family member's house. She stated staff member A told her that resident #2 could sign AMA (against medical advice) paperwork the following day to be discharged from the facility. NF3 stated she was able to convince the resident to return to the facility the following day, and he was readmitted , and he did not sign AMA paperwork. She stated the facility agreed to allow the resident back with some stipulations, to include that NF3 would always take him to any outside appointments, that he could not leave the center without her, and he would not be able to do things such as taking walks without direct supervision. The resident was also supposed to take his medications as prescribed. NF3 stated the facility did not have a care plan meeting with her or the resident after the elopement.Review of a facility reported incident, dated12/16/25 at 4:00 p.m., showed, Incident Description: [Resident #2] was taken to a dentist appointment and refused to come back to the facility. He took a taxi to his (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[relative's] house where he used to live. The police were called and met him and I at his [relative's] house and were unable to convince him to come back to the facility. His POA was notified and was also unable to convince him to come back to the facility. [Resident #2] has decided to stay at [relative's] house where he used to live for the time being. No injuries noted. He was left by the police and I at his [relative's] house because he was deemed safe for the evening by the police and [NF3].Review of the facility reported incident findings, dated 12/22/25, showed, [Resident #2] . has a current BIMs of 12. We took [Resident #2] to a dentist appointment and while there he decided to call a taxi and leave and go to his [relative's] house where he used to live with her. I immediately called the police and reported it and went to his [relative's] house where I was met by the police and [resident #2]. [Resident #2] . stated that he didn't want to live at [Facility Name] anymore and that he was going to live on his own again. He also expressed the desire to hitchhike or take a bus to [NAME] to visit his friends, even though his sister confirmed with him that they had all passed away years ago or were in prison. He was undeterred by this and insisted that he was going because he didn't believe her . he ultimately decided that he was not coming back . [NF3] agreed that he could spend the night at [relative's] house because he was safe . [NF3] said she would come by in the morning and get his things and sign the [Against Medical Advice] paperwork. The next morning [Resident #2 and NF3] arrived . decided that he had made a mistake and wanted to come back and be a resident here. We agreed to take him back with some stipulations. [Resident #2] agreed to start taking his meds again as well as agreeing that for every appointment he goes on, [NF3] will accompany him. They both agreed, and we readmitted [Resident #2]. There have been no further issues with [resident #2] since his readmission. The document showed the incident was not verified for abuse. 1. Develop Care Plan Interventions to Reduce Risk of ElopementReview of resident #2's Wandering and Elopement Risk Evaluation, dated 9/4/25, showed the resident was a wander and elopement risk after the resident had, .disclosed to his sister that he wants to take a 2-week vacation and visit friends that have passed or incarcerated. Additionally, the Elopement Evaluation showed, Recommendations for safety: Monitor more frequently, advise staff of risk, update care plan and patient and family to report to staff if leaving the facility. Summary/Conclusions and rationale for care plan decision: Resident expressed a desire to leave to his sister on the phone and has been asking about the streets located near the facility. He has noted mental health problems and may hear voices.Review of resident #2's Nursing Progress Note, dated 11/16/25, showed, [NF3] approached this RN today and stated that she is concerned about statements that resident made today during her visit . resident continues to express a desire to elope from the facility . he resents her for putting him here. The staff member assured NF3 that since the resident was an elopement risk, the staff will continue to watch him closely, and the concerns would be documented in a progress note on the 24-hour report.Review of resident #2's IDT Progress Note, dated 12/2/25, showed the IDT had discussed recent behaviors related to the resident's mental health, but the note did not address concerns related to his wandering or NF3's concerns related to his elopement risk. There were no IDT notes documented from 12/2/25 to 12/16/25.Review of resident #2's Nursing Progress Note, dated 12/3/25, showed, 12/2/25 [5:30 p.m.] attempted to sign self out and leave facility, cued by administration that it is winter and it is snowing, and he needs someone to go with him if he goes on an outing, returned to his room and no further attempts made to leave facility.Review of resident #2's Care Plan, with an initiation and revision date of 9/4/25, showed the resident was an elopement risk/wanderer related to verbalization of wanting to leave. The goal established showed, Resident will not leave the facility unattended through the review date. The facility established interventions with an initiation date of 9/4/25, and there was a revision date of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/8/25, which showed: - Address wandering behavior by walking with or attempt to redirect from inappropriate area; engage in diversional activity.- Complete Elopement Risk Assessment upon admission, quarterly and with significant change in status.- Determine lifestyles that may trigger episodes of elopement.- Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.- Monitor location every hour. Document wandering behavior and attempted diversional interventions in behavior log.- Photograph of [resident#2] in wander notebook. [sic]Review of resident #2's Care Plan did not address the interventions outlined by NF3 for supervised walks and supervised office visits when NF3 could not attend the visit. The care plan also failed to address interventions regarding increased risk of elopement when medications were refused, interventions for when the resident was expressing a desire to leave the facility to visit friends in another state, or interventions to monitor his sleep patterns.During an interview on 1/7/26 at 10:40 a.m., staff member C stated that when a resident was determined to be a wander/elopement risk, the expectation was to complete a care plan that included interventions specific to the resident to reduce the risk of elopement. The expectation was to update the resident's care plan for interventions as needed or when new revisions were necessary.2. Revise Care Plan Post-ElopementDuring an interview and record request on 1/7/26 at 10:40 p.m., staff member C stated a resident's care plan should be reviewed and revised after an elopement. She stated resident #2's care plan was revised and updated at the time of his re-admission, on 12/17/25. She stated the Clinical Evaluation admission Form will trigger a baseline care plan to be completed. The documents will auto-populate a canned text for the baseline care plan, which can be personalized.Review of resident #2's Clinical Evaluation Admission, dated 12/17/25, showed that the resident was alert, oriented to self, and had a history of elopement. A Wander/Elopement baseline care plan was triggered. The document showed the following elements for a baseline care plan:Focus: is an elopement/wander risk r/t [blank]. Will not leave facility unattended. Intervention: Complete Elopement Risk Assessment upon admission, quarterly, and with significant change. Intervention: Distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, magazine, photo album. Task: Monitor # of [Specify: exit seeking attempts, wandering episodes] each shift. Task: Wander Guard check placement to [blank] at the beginning of each shift. No additional individualized resident-centered interventions were developed on 12/17/25.Review of resident #2's Care Plan with an initiated date of 12/17/25, and a revision date of 12/26/25 showed the resident was an elopement risk related to the wander/elopement assessment. The established goal showed the resident will not leave the facility unattended, and there were the following interventions: - Address wandering behavior by walking with or attempting to redirect from (the) inappropriate area; engage in diversional activity. Date Initiated: 12/26/2025- Complete Elopement Risk Assessment upon admission, quarterly, and with significant change. Date Initiated: 12/17/2025.- Distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, magazine, photo album. Date Initiated: 12/17/2025- Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date Initiated: 12/26/2025- Monitor [number sign] of [Specify: exit seeking attempts, wandering episodes] each shift. Date Initiated: 12/17/2025.The care plan did not address interventions as discussed by the family after resident #2's elopement, which addressed family-supervised facility outings and medication management.During an interview on 1/7/26 at 10:40 a.m., staff member C stated a resident's care plan was to be reviewed and modified following an elopement with updated interventions to reduce the risk of repeated elopement attempts.3. Behavior MonitoringReview of resident #2's Nursing Behavior Progress Note, dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275044	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Ascension Transitional Care of Cascadia	2475 Winne Ave Helena, MT 59601

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/19/25, showed, 11/18/25 6p-6a . resident is not sleeping during the night, up all night, at times pacing in hallways .Review of resident #2's Physician Orders, and Treatment Administration Records, for behavior monitoring, from 9/1/25 to 12/16/25, did not show the resident was being monitored for wandering or his exit-seeking behavior.During an interview on 1/7/26 at 10:40 a.m., staff member C stated a resident who was determined to be an elopement risk would have regular behavior monitoring to assess the resident for elopement behaviors, in an attempt to reduce the risk for elopements. She stated the behavior monitoring would be completed by staff, as ordered by the provider.4. SupervisionDuring an interview on 1/6/26 at 9:27 a.m., staff member L stated he transported resident #2 to a dental appointment on 12/16/25, leaving the facility around 2:40 p.m. He stated he was aware the resident was not to be left unsupervised during the visit. He stated NF3 was supposed to be there, but she did not show up for the appointment. He stated he waited with the resident until the resident was escorted back to the exam room. He said he believed the resident would be safe while the resident was with the doctor, so he decided to make a quick trip to pick up some paperwork from another facility. He said when he returned, he was informed by the dental office staff that the resident had already left. Staff member L stated he had received training on elopement management and protocols when he started at the facility approximately one year ago.Review of resident #2's Appointment Calendar showed an appointment was scheduled at a dental clinic on 12/16/25 from 2:40 p.m. to 3:40 p.m. A note provided in the description of the appointment showed, [Resident #2] .for dental pain. PLEASE STAY WITH HIM ELOPMENT RISK sister will be there a few min after 3. [sic] During an interview on 1/7/26 at 10:53 p.m., staff member A stated it was the expectation that a staff member was to stay with a resident who was a known elopement risk when being transported to and from doctor's appointments.5. Investigate ElopementDuring an interview and record request on 1/7/26 at 10:40 p.m., staff member C stated there was no IDT meeting or an after-action plan completed for the investigation of resident #2's elopement on 12/16/25. She stated it was the facility's expectation that the IDT meeting and after-action plan be completed at the time of an event, such as an elopement, and there were established policies and procedures that address the process. Staff member C stated they did not have documentation on an after-action post-elopement/wandering evaluation.During an interview on 1/7/26 at 10:53 p.m., staff member A stated they did not complete anything other than the facility-reported incident for resident #2's elopement. He stated there was an IDT meeting, and they discussed the events surrounding resident #2's elopement, but they did not have the discussion documented. He stated that, since the resident was determined to be safe, and he wanted to leave against medical advice, they did not complete an after-action plan. He stated they treated the situation like a discharge since the resident did not want to return to the facility.6. Elopement Evaluation post Elopement.During an interview on 1/7/26 at 10:53 p.m., staff member A stated that following resident #2's elopement from the dental office, resident #2 was determined to be safe at a relative's house. He stated they decided to allow the resident to stay the night at the relative's house because he refused to return to the facility. He told NF3 that if the resident did not wish to return to the facility, they could come to the facility the next day (12/17/25) and have them sign AMA paperwork. He stated that when the resident returned to the facility on [DATE], with NF3, he had decided that he wanted to stay at the facility and no longer wished to leave. Staff member A stated they re-admitted the resident to the facility on [DATE].During an interview and record request on 1/7/26 at 10:40 p.m., staff member C stated it was the expectation that a wandering/elopement evaluation was to be completed as soon as possible when a resident was admitted to the facility and triggered for a risk of elopement. She stated it was also the expectation that a new elopement evaluation was to be completed on a resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately following an elopement to ensure there were no changes. Review of resident #2's Progress Notes showed the resident was re-admitted to the facility on [DATE]. Review of resident #2's Clinical Evaluation Admission, dated 12/17/25, showed that the resident was alert, oriented to self, and had a history of elopement, and a Wander/Elopement baseline care plan was triggered. An elopement evaluation was not completed until four days after the resident returned to the facility: 12/21/25. Review of resident #2's Elopement Evaluation, dated 12/21/25, showed the resident was at risk for elopement related to his cognitive impairment, wandering, impaired decision-making, safety awareness, expressed desire to leave the facility, and his expressed anger at being placed in the facility. The elopement evaluation showed, [Resident] will often try to sign himself out. The recommendations for the resident's safety showed, follow plan of care. A review of the facility's policy and procedure, titled Elopement, released 9/16/25, showed: . 7. Complete an Elopement/Wandering Evaluation of the resident post elopement incident with continued follow up documentation as clinically indicated.8. The Interdisciplinary Team will investigate the incident, identify contributing factors and root cause analysis, and document findings and recommendations in the medical record and plan of care updated as indicated.A review of the facility's policy and procedure, titled Unsafe Wandering and Elopement Prevention, with a review date of 9/5/25, showed: .7. The interdisciplinary team will review and update the care plan as needed following each comprehensive assessment, significant change in condition, quarterly MDS, or any incident involving unsafe wandering or elopement.