

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Elkhorn Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  474 Hwy 282 Clancy, MT 59634	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>51133</p> <p>Based on interview and record review, the facility failed to report the findings of an investigation for an alleged resident-to-resident abuse incident for resident # 8 and #18, within five working days of the incident. Findings include:</p> <p>Review of the Facility Reported Incident of abuse, involving resident #8 and 18, showed the incident occurred on 8/13/24 at 11:30 a.m.</p> <p>Review of the facility's document, Reportable Incident for resident #'s 8 and 18, showed, Findings - submitted on 8/26/24.</p> <p>During an interview on 12/17/24 at 9:37 a.m., staff member A stated she had not submitted the findings for this incident within five working days.</p>

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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