STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275069	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hot Springs Health & Rehabilitation Center	600 1st Ave N Hot Springs, MT 59845

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 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. Based on interview and record review, the facility failed to develop comprehensive care plans that included resident-specific care items and or accurate levels of care required for ADLs for 4 (#s 2, 11, 22, and 28) of 19 sampled residents. The deficient practice placed residents at risk for unmet care needs and at risk for not maintaining their highest practicable level. Findings include:During an interview on 2/9/26 at 8:08 a.m., staff member A stated the facility followed the RAI manual as the care planning policy. Staff member A stated he wasn't sure why some CAAs were not on the care plan.During an interview on 2/9/26 at 10:38 a.m., staff member A stated they are following the new objectives on cutting down on care plans. During an interview on 2/9/26 at 11:52 a.m., staff member C stated the IDT is involved in care planning, but any nurse can update a care plan as necessary. The care plans are updated as individual needs come up for the residents.During an interview on 2/9/26 at 2:26 p.m., staff member A stated he would expect to see the individual needs of a resident on the care plan and would expect it to be inclusive but condensed enough to read. During an interview on 2/9/26 at 2:52 p.m., staff member G stated when a CAA was triggered on the MDS it should be addressed in the care plan. Staff member G stated once section V of the MDS was completed, the comprehensive care plan was updated based on triggered areas. Staff member G stated she made sure the care plan had been updated for the triggered areas prior to submission of the MDS. Staff member G stated that care plans were updated by the department managers when an MDS was being completed and the need for updates were identified and reviewed by the Interdisciplinary Team as a whole. Staff member G stated weekly updates were completed during the utilization review meeting. Staff member G stated when she found changes in the sections of the MDS she updated the care plan at that time. Staff member G did not know why some of the care plans did not reflect some of the areas triggered in the MDS, but it was possible some of the ADLs got missed.a. A review of resident #2's Comprehensive MDS, with an ARD of 5/19/25 showed, resident #2 refused bathing and was dependent for oral hygiene.A review of resident #2's Quarterly MDS, with an ARD of 1/28/26 showed, resident #2 required substantial/maximal assistance with bathing and substantial/maximal assistance with oral hygiene.A review of resident #2's care plan, updated 2/8/26 showed, Needs limited to extensive assist with bathing and failed to identify the level of care needed for oral hygiene.b. A review of resident #22's Comprehensive MDS, with an ARD of 7/28/25 showed, resident #22 was dependent for bathing.A review of resident #22's Quarterly MDS, with an ARD of 1/15/26 showed, resident #22 was dependent for bathing.A review of resident #22's care plan, updated 1/27/26 showed, Bathing: Bathe/shower self Extensive assistance of one staff. [sic]c. A review of resident #28's Comprehensive MDS, with an ARD of 8/11/25 showed, resident #28 required partial/moderate assistance with tub/shower transfers and partial/moderate assistance with bathing. Resident #28 was marked on the MDS as being at risk for developing pressure ulcers/injuries. The CAA worksheet indicated this risk would be addressed in the care plan.A review of resident #28's Quarterly MDS, with an ARD of 1/28/26 showed, resident #28 required supervision or touch assistance with tub/shower transfers and partial/moderate assistance with bathing. It also showed resident #28 was at risk for developing pressure ulcers/injuries.A review of resident #28's (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan, updated 1/28/26 showed, the care plan did not contain a level of assistance for tub/shower transfers or bathing. The care plan did not identify that resident #28 was at risk for developing pressure ulcers/injuries or include interventions to prevent or relieve pressure areas.d. A review of resident #11's Comprehensive MDS, with an ARD of 1/7/26 showed, resident #11 was dependent for bathing. The MDS indicated resident #11 did not walk 10 feet. This was coded as 09. Not applicable- Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.A review of resident #11's care plan, updated 1/27/26 showed, the care plan did not contain a level of assistance for bathing and listed a non-pharmaceutical pain intervention of walking with supervision.A review of the Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, effective 10/1/25, showed: . Chapter 4: Care Area Assessment (CAA) Process and Care Planning. the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment. The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care. The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. it is expected that nursing homes will assess resident needs, plan care and implement interventions in a timely manner.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to maintain a clean bathroom for the resident(s) to use for 1 (#5) of 19 sampled residents. This deficient practice caused the facility to be odorous of urine. Findings include:During an observation on 2/7/26 at 12:39 p.m., the bathroom located outside of resident #5's room had a urine odor. There was what appeared to be urine built up at the base of the toilet. When wiped with a dry white cloth, the cloth became soiled with urine. During an observation on 2/8/26 at 8:20 a.m., the bathroom near resident #5's room smelled of urine, and there was what appeared to be urine built up around the base of the toilet. There was a toilet riser over the toilet, and the lid to the toilet tank was missing. When a paper towel was used to wipe the spot of urine in front of the toilet, the paper towel became soiled with urine.During an observation on 2/8/26 at 10:27 a.m., staff member J was cleaning the bathroom next to resident #5's room. During an observation on 2/8/26 at 11:11 a.m., the bathroom next to resident #5's room still smelled of urine, and the spot that appeared to be urine was still apparent on the floor in front of the base of the toilet. The lid to the back of the toilet was now on the back of the toilet. During an interview on 2/8/26 at 12:30 p.m., staff member J stated the bathroom next to resident #5's room was cleaned daily. Staff member J stated the bathroom next to resident #5's room is not just for resident #5; it is a communal bathroom, and it gets used quite a bit. During an observation and interview on 2/9/26 at 9:01 a.m., staff member F stated the bathroom next to resident #5's room is cleaned daily and deep cleaned once a month. When staff member F observed the bathroom, she stated, That looks like urine. The urine spot in front of the toilet was still present, and when wiped with a white cloth, the cloth became soiled with urine. Staff member F stated, I will get right on it and clean that bathroom. Review of a facility email document titled 5 Step Room Cleaning with an emailed date of 2/8/26 showed: 5 Steps Room Cleaning.3. Vertical surfaces (look for spills, markings, stains. All vertical surfaces are not cleaned daily, but should be inspected and spot cleaned)4. Dry mop5. Damp mop.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to assess a resident for the risk of entrapment from bed rails and failed to obtain consent from the resident's POA, prior to installation of grab bars for 1 (#38) of 19 sampled residents. The deficient practice had the potential to cause an entrapment risk for the resident. Findings include:During an observation on 2/8/26 at 1:11 p.m., resident #38 was sleeping in his wheelchair, in his room, next to his bed. His bed was noted to have two bed rails/grab bars, one on each side of his bed.During an interview on 2/8/26 at 2:56 p.m., staff member A stated resident #38 should not have had bed rails, they were mounted to his bed and should not have been. Staff member A further stated that both bed rails had been removed.During an observation on 2/9/26 at 10:45 a.m., resident #38 was sitting in his wheelchair watching tv and there was a bed rail up on the room door side of the bed.During an interview on 2/9/26 at 10:51 a.m., staff member E stated he had only removed the bed rail on the window side of the bed.During an interview on 2/9/26 at 10:52 a.m., staff member C stated that both of resident #38's bed rails were removed yesterday.A review of a facility policy titled, Physical Restraints and Enablers/Devices, with a updated date of January 2025, showed: Policy Statement: It is the policy of this center that residents have the right to be free from any physical restraints imposed for purposes of discipline or staff convenience, and not required to treat the resident's medical symptoms. Restraints are only used to treat the resident's medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining the highest practicable level of physical and psychosocial well-being.DEFINITIONA physical restraint is defined as, 1 'Any manual method, physical or mechanical device, equipment or material attached or adjacent to the resident's body that meets all of the following criterion:Is attached or adjacent to the residents body;Cannot be removed easily by the resident; andRestricts the resident's freedom of movement or normal access to his/her body.' .2. If it is determined that a resident has symptom necessitating the use of a physical or a mechanical device, the Device Evaluation is completed prior to the device being initiated, annually and on change of condition, if the condition affects the use of the device. The 'EFFECT NOT THE INTENT' is evaluated to determine if the device used is a restraint or an enabler. If it is determined that restraint usage is needed, the least restrictive device is used.a. Devices may include but are not limited to the following: i. Bed rails (quarter, 1/2, 3/4 full) .5. The resident and/or resident representative is provided risks/benefits of restraint use or enabler/device use, and consent obtained prior to implementation of the device. 8. The resident is evaluated using the Device Evaluation on admission, re-admission, annually, and with significant change in condition (as the condition change applies to the use of the restraint or device), for the continued need for the device and evaluation of the effect on the resident.[sic]A request for a bed rail/grab bar consent and an assessment/evaluation for resident #38 was made on 2/8/26 at 1:23 p.m., and was not received by the end of the survey period.