

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2025
NAME OF PROVIDER OR SUPPLIER  Cooney Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2555 E Broadway 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to fully investigate, have a consistent process of investigating, and document the investigations for four Facility Reported Incidents (FRI) that were reviewed during the time of survey for 4 (#s 1, 3, 4, and 5) residents out of the 5 sampled, and resident injuries occurred for some of those residents. This deficient practice had the potential to result in a higher occurrence of similar incidents, as the root cause may have never been identified. Findings include: Review of a facility policy, titled Incidents and Accidents, not dated, showed: - Policy: It is the policy of this facility to utilize Bounds and PCC . to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property or may involve or allegedly involve a resident. -The purpose of incident reporting can include: . Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. [sic]-15. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it.Listed below is a summary of the four Facility Reported Incidents:1. Review of a FRI that occurred on 10/29/24 showed an incidental finding of a fracture on resident #3. The facility completed resident questionnaires for four residents, but did not include resident #3 in the interviews. No staff interviews were conducted for the staff who might have been on duty around the time the fracture might have occurred. No resident representative interviews were conducted. There was also no documented root cause analysis of the resident injury. 2. Review of a FRI that occurred on 4/16/24 for resident #4 showed an unwitnessed fall and abrasion, which resulted in a hospital visit. The interdisciplinary team identified the root cause, but no staff or resident interviews were completed or documented, including the resident who fell.3. Review of a FRI that occurred on 10/16/24 for resident #5 showed a resident's family member was concerned and wanted the resident sent to the hospital. The resident's family member had voiced this concern to a CNA. The FRI investigation showed an interview with the nurse, but did not show a documented interview with the resident, the resident's family member, the CNA, or any other staff members who may have been involved. There was no root cause analysis as to why the incident might have occurred.4. Review of a FRI that occurred on 7/8/25 showed resident #1 fell in the [Entity Name]'s parking lot, was transferred to the hospital, and later passed away from comorbidities and surgery. The investigation of the incident failed to show resident #1's or staff member C's interview of the situation. Although resident #1 was hospitalized , staff member M stated they had talked to the resident at the hospital about what had happened on 7/8/25. There was also no documentation of the potential root causes related to the event. During an interview on 8/5/25 at 3:13 p.m., staff member A stated the Facility Reported Incidents were not thoroughly investigated because of changes in upper management and a multitude of duties falling on staff member A. Staff member A stated a thorough investigation should have been completed.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2025
NAME OF PROVIDER OR SUPPLIER  Cooney Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2555 E Broadway 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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interview and record review, the facility failed to ensure a comprehensive person-centered care plan was in place for 2 residents (#s 1 and 2) of 3 sampled residents. This resulted in one resident falling in the parking lot while using her motorized wheelchair while she was outside of the facility. Findings include: 1. Review of resident #1's care plan, with an initiation date of 8/9/23, showed:- Focus: (resident #1) has physical functioning deficit related to weakness, recent acute illness, activity intolerance, and obesity. -Interventions/Tasks: Electric and manual w/c . The care plan did not mention if the resident was able to leave the building for appointments using her motorized wheelchair with or without the accompaniment of staff. The care plan did not distinguish specific staff that were required to accompany the resident and did not address the need for verbal cues that was mentioned on the occupational therapy evaluation. Review of resident #1's occupational therapy assessment showed Power-Mobility Indoor Driving Assessment: Score Sheet. The written score was a 96% out of 100% with the comments: Resident cleared for in the facility with outside requiring close supervision and verbal cues for safety. During an interview on 8/5/25 at 10:34 a.m., staff member J stated the residents would often walk if able, or be transported with their wheelchair or motorized wheelchair across the [Entity Name]'s parking lot to go to appointments instead of taking the facility's van. 2. During an interview on 8/6/25 at 9:14 a.m., resident #2 stated she had taken her motorized wheelchair through the [Entity Name]'s parking lot to get to an appointment a couple of times, but preferred the van. She stated she liked the facility's van, but did not like the currently borrowed van as it had a manual lift. She stated she felt uncomfortable and a bit unsafe, going up the steep ramp in her motorized chair. Review of resident #2's care plan, with an initiation date of 8/5/25, showed: Electric W/C for locomotion around facility. The facility failed to show the resident's preference for the use of a van instead of using her motorized wheelchair, and failed to show if resident #2 was safe to use her motorized wheelchair outside of the facility and to go to appointments. Review of a facility policy, titled Comprehensive Care Plans, with a revision date of 6/2/25, showed:- Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.-8. Qualified staff responsible for carrying out interventions specific in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2025
NAME OF PROVIDER OR SUPPLIER  Cooney Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2555 E Broadway 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 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2025
NAME OF PROVIDER OR SUPPLIER  Cooney Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2555 E Broadway 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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Based on interview and record review, the facility failed to ensure that 1 (#1) of 3 sampled residents was kept safe while using her motorized wheelchair in the [Entity Name] parking lot while coming from an appointment. This deficient practice resulted in a resident falling outside of the facility and suffering from multiple fractures, which resulted in hospitalization; and the residents using motorized wheelchairs did not feel safe when being transported due to the type of transport offered or used, for 2 (#s 1 and 2) out of three sampled residents. Findings include: Review of resident #1's EHR showed a BIMS of 15, cognitively intact. A weight of 357.8 pounds (as of 6/8/25), and a consistent oxygen requirement of three liters per minute. Resident #1's relevant diagnoses were: Type 2 diabetes, obesity, chronic obstructive pulmonary disease, acute on chronic diastolic (congestive) heart failure, unspecified atrial fibrillation, osteoarthritis, contusion of left lower leg, long-term use of anticoagulants, and pulmonary hypertension. During an interview on 8/5/25 at 7:40 a.m., staff member M stated resident #1 was 100% cognizant and was cleared to operate her motorized wheelchair independently around the facility. Staff member M stated resident #1 required a staff member when leaving the facility on her motorized wheelchair. Staff member M stated the day of 7/8/25, resident #1 had been short of breath and could not keep her oxygen saturations up during her rehabilitation. Staff member M stated her oxygen requirements increased to four liters per minute, which was not her normal. Staff member M stated resident #1 was later suspected of a pulmonary embolism (PE). Staff member M stated resident #1 went to the hospital to get a CT, but refused to go in the van and did not want to go with EMS. Staff member M stated resident #1 was an obese woman and felt that when she traveled with EMS, they would have to manhandle her, which she did not like. Staff member M stated on the way back from the scan, resident #1 hit a speed bump in her motorized wheelchair, fell out, broke her femur, and was transferred to the hospital. Staff member M stated they were unsure why this happened, as resident #1 was able to complete high-level assessments while driving her motorized wheelchair. Staff member M stated the long-term goal for resident #1 was to go to an assisted living facility. Staff member M stated this was partly why a motorized wheelchair was ordered in the first place. During an interview with staff member B and H, on 8/5/25 at 10:52 a.m., staff member B stated the incident occurred (resident falling from wheelchair) with resident #1 because occupational therapy had not cleared the resident to be transported with any other staff members other than a physical therapist or occupational therapist specifically. Staff member B stated a nurse had taken resident #1 over to the hospital, and a transport staff member took her back to the facility. Staff member B stated that right after the incident, staff member D called the facility, and staff member C responded to the incident, who then called 911. Staff member B stated that staff member D should have called 911 right away. Staff member H stated staff member D sat resident #1 up, after she fell because the resident had told staff member D that the pavement was too hot. Staff member B stated staff member D acted negligently because staff member D did not call 911 immediately and moved the resident without a proper evaluation first. Staff member B also stated staff member D had a history of not completing job duties correctly and delegating orders. Review of resident #1's occupational therapy assessment showed Power-Mobility Indoor Driving Assessment: Score Sheet. The written score was a 96% out of 100% with the comments: Resident cleared for in facility with outside requiring close supervision and verbal cues for safety. During an interview on 8/5/25 at 11:08 a.m., staff member K stated resident #1 had met all goals regarding her motorized wheelchair. She was at a supervisory level when outside. Staff member K stated a physical therapist or occupational therapist did not have to be with resident #1 when the resident was outside, as the Rehabilitation Department had cleared the resident to have met this goal. Staff member K stated, She (the resident) was at a supervision level so anyone could have watched her. During an interview on 8/5/25 at 11:24 a.m., staff member C stated that morning, staff member C and resident #1 went over the same speed bump with no issues. Staff member C stated that they later got a call from staff member D, went to the scene, and then called 911. Staff member C stated that resident #1 must have just hit the curb wrong, and it was an unfortunate accident. Staff member C stated that resident #1 would have gone to the hospital by herself if staff member C had not offered to go with her. Staff member C stated that resident #1 did not have a phone, so if something had happened, she would have been out there alone. Staff member C stated it did not look like resident #1 was moved when staff member C came on to the scene, but they stated it was hard to say, as resident #1 was sitting up, and staff member C did not know how she landed. Staff member C stated staff member D described what happened as resident #1 fell out of the chair on her hands and knees</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2025
NAME OF PROVIDER OR SUPPLIER  Cooney Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2555 E Broadway 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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on interview and record review, the facility failed to ensure resident safety by providing the appropriate competencies to all staff regarding transportation services when staff were assisting outside the facility. This deficient practice resulted in a resident falling in the parking lot, being ejected from their motorized wheelchair, and this resulted in 1 (#1) resident being transferred to the hospital. Findings include: During an interview on 8/5/25 at 2:49 p.m., staff member G stated all onboarding trainings, job titles, and job duties should be located in the staff files. Staff member G stated that clinical trainings were located in a separate file in staff member B's office. During an interview on 8/5/25 at 3:13 p.m., staff member B stated all onboarding documentation should be signed and dated by the staff member. Staff member B stated all staff were educated on the new transportation policy, including what to do in a scenario where a resident fell, and also checking in with Rehabilitation Therapy and the DON before transferring a resident outside of the facility. Review of staff member D's file showed no yearly evaluations (including no demonstration of skills or ability, review of adverse events, gaps in competency, or demonstrated ability to perform activities that were within the staff member's scope of practice) since the hire date in 2020. No job title or job duties related to their position, and no education related to their specific job role, were located in this file. Review of staff member D's yearly education showed mostly computer-based training and no training that tested for critical thinking skills or the ability to manage care in complex environments. During an interview on 8/6/25 at 9:01 a.m., staff member H stated the facility could not find any yearly evaluations or competencies for staff member D. Staff member H stated the facility did not have any transportation education for any of the staff before the incident with resident #1 on 7/8/25. During a return phone call on 8/7/25 at 9:03 a.m., staff member D stated, It's been a long time (since any education was given regarding transportation), I don't even remember how long it's been. According to the State Operations Manual, These competencies are critical in order to identify potential issues early, so interventions can be applied to prevent a condition from worsening or becoming acute. Without these competencies, residents may experience a decline in health status, function, or need to be transferred to a hospital.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2025
NAME OF PROVIDER OR SUPPLIER  Cooney Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2555 E Broadway 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)		
<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on interview and record review, the facility failed to ensure new and existing staff: were properly educated concerning the transportation of residents; yearly evaluations were completed and documented; and written job titles and duties were located in the staff files. This deficient practice had the potential to result in staff feeling unprepared and potentially not knowing their roles. Findings include: During an interview on 8/5/25 at 2:49 p.m., staff member G stated all onboarding trainings, job titles, and job duties should be located in the staff files. Staff member G stated clinical trainings were located in a separate file in staff member B's office. During an interview on 8/5/25 at 3:13 p.m., staff member B stated all onboarding documentation should be signed and dated by the staff. Staff member B stated all staff were educated on the new transportation policy, including what to do in a scenario where a resident fell, and checking with Rehabilitation Therapy and the DON before transferring a resident outside of the facility. Review of staff member F's employee file showed all of the onboarding documentation was in staff member F's file, but the documentation was blank. The facility was able to provide electronically signed documentation; however, these documents were not dated. Staff member F worked the floor 8/4/25. Review of staff member D's file showed no yearly evaluations since their start date in 2020, no job title, or job duties related to their position, and no education related to their specific job role. There was no driver's license present in staff member D's file. Review of facility policy, titled Transporting a Resident (Facility Van), not dated, showed: 8. Staff authorized to drive the van will have necessary training and licensure to operate the vehicle as well as knowledge on van safety features. Copies of any necessary documentation will be kept in each employee's personnel file. During an interview on 8/6/25 at 9:01 a.m., staff member H stated the facility could not find any yearly evaluations or competencies for staff member D after the changes in administration over the past year. Staff member H stated the facility did not have any transportation education for any of the staff prior to the incident with resident #1 on 7/8/25. During a return phone call on 8/7/25 at 9:03 a.m., staff member D stated, It's been a long time (since any education was given regarding transportation), I don't even remember how long it's been. During an interview on 8/5/25 at 10:34 a.m. with staff member J and I, staff member J stated they did receive the education on the new policy but still felt confused about what to do if a resident asked them personally to walk over to the hospital. Staff member I stated they were too new and did not know the new policy. Staff members I and J stated this would probably never be a problem as this was not their job duty.</p>		