STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275080	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cooney Healthcare and Rehabilitation	2555 E Broadway Helena, MT 59601

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interviews and record review, the facility failed to ensure a resident or representative was provided written notifications of room changes, for 1 (#2) of 19 sampled residents, and room changes reportedly caused the resident frustration and anxiety, which the representative wanted to avoid, but she was not provided the opportunity to be present to assist the resident with the room changes. Findings include:During an interview on 12/3/25 at 1:10 p.m., NF1 stated she was very angry about the room move completed for resident #2, which occurred on 11/3/25 and 11/11/25. NF1 stated she was not notified when resident #2 would be moved, even after she requested the notice, so she could assist resident #2 through the move. NF1 stated resident #2's dementia made the room changes more difficult for him, causing him frustration and anxiety. NF1 stated the facility, Just moved him, with no warning, no paperwork signed, and it was the second time they have done this (moved him without notice). Review of resident #2's EHR Census page, dated 12/3/25, reflected that resident #2 had been moved on 11/3/25 for rehabilitation and 11/11/25 for long-term care.Review of resident #2's EHR progress notes, dated 5/21/25 - 12/3/25, reflected no progress notes related to the room changes or adjustment of the resident for the room change. Review of resident #2's EHR documents (misc.), dated 5/21/25 - 12/3/25, reflected no room change consent forms were signed by the resident's representative for the notification. During an interview on 12/3/25 at 2:18 p.m., staff member F stated she did not get a consent signed by resident #2's representative because she thought an email she received from NF1 would be sufficient. Staff member F stated she should have read the email closely, as the email was a request to discuss a room move, and it was not a consent to move him. Staff member F stated NF1 was very angry, and she understood why when NF1 explained her reasons for wanting to be present.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual 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. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interviews and record reviews, the facility failed to ensure a comprehensive grievance process was operationalized and followed effectively by staff for the resolution of grievances received, for 9 (#s 2, 3, 4, 5, 12, 13, 14, 15, and 16) of 19 sampled residents. This deficiency resulted in multiple grievances being mishandled, including ones not reported to the State Survey Agency, about abuse or neglect of care. Findings include:1. During an interview on 12/3/25 at 1:10 p.m., NF1 stated she was very angry about the room changes done for resident #2 on 11/3/25 and 11/11/25, because she was not notified when resident #2 would be moved. NF1 stated she also reported concerns about the safety of doors on the rehabilitation unit being left unlocked at night, along with the front door being locked at night, but no one was answering the door when she brought resident #2 back from an outing. NF1 stated she filed a complaint with staff members A and F regarding her concerns with the room changes and lack of notification, as well as the concerns with the doors. During an interview on 12/3/25 at 2:18 p.m., staff member F stated she did not obtain a consent signed by resident #2's representative for the room changes. Staff member F stated she did not complete the grievance form for NF1's concerns because she and staff member A talked to NF1 and apologized. Staff member F stated that no further investigation was completed or documented for the grievance. 2. Review of a grievance, dated 11/10/25, reflected that resident #12 complained that a CNA left her in bed naked, after the CNA complained about changing the resident's brief, and hurting her by leaving her covered in urine and feces overnight. The sections on the grievance form labeled Immediate corrective action taken, Documentation of investigation, and Resolution were not filled out.During an interview on 12/3/25 at 1:30 p.m. , resident #12 stated the CNA left her sitting in urine and feces all night. Resident #12 stated the CNA changed her in the morning, then left her in bed naked after complaining about having the change her brief. Resident #12 stated the CNA was supposed to get the resident up, but did not. Resident #12 stated she did not receive a response to her grievance she filed about the lack of care, but had heard that CNA was not working at the facility anymore. 3. Review of a grievance, dated 11/10/25, reflected that resident #3 filed a grievance about a CNA who yelled at her, and then threw a blanket on her. Resident #3 stated the CNA refused to get her a drink, and when she requested a nurse, the CNA was mean. The grievance section labeled for the immediate actions taken, reflected, [Resident #3] clarified w/SSD that the blanket. [sic] On the back of the grievance form was a documented note which showed, SSD spoke with [Resident #3] about this. she reported she is ok. feels safe. I did let [Resident #3] know that this staff (the CNA) would likely not be returning (to work at the facility). she said OK . During an interview on 12/2/25 at 8:42 a.m., resident #3 stated she needed help on 11/10/25, and the CNA refused to assist her with toileting and was not doing the brief check and changes. Resident #3 stated the CNA yelled at her, and then resident #3 kicked the CNA out of her room. Resident #3 stated staff member F had just stopped by and told her the CNA would not be working at the facility anymore. During an interview on 12/4/25 at 1:35 p.m., staff member F stated she just completed the documentation note on the back of the grievance form from resident #3, and staff member A backdated the signature on the grievance after the surveyor requested the documents, as it was not done. 4. Review of a grievance, dated 11/10/25, reflected resident #13 filed a grievance regarding care on 11/9/25. The grievance reflected that the staff-to-patient ratio was unacceptable. The grievance went on to reflect that resident #13 was still in her pajamas at noon and waited for her call light to be answered for over an hour, a wound dressing was not dated, and resident #13 had a UTI. On the back of the form was a note that showed the DON had met with staff about wound care protocols, and staff members A and F had met with the resident's family about what was being done (provision of care) during times of short staffing. It was later identified that the weekend staff involved were reported to the State Survey Agency.During an interview on 12/4/25 at 1:35 p.m., staff member F stated she just completed the documentation note on the back of the grievance form from resident #13, and staff member A backdated the signature on the grievance after the surveyor requested the documents.5. During an interview on 12/2/25 at 3:07 p.m., NF2 stated she and her daughter both filed grievance forms regarding #16's fall on 11/10/25, to include abuse by staff. NF2 stated resident #16 tried to brush his teeth and fell. The nurse and CNA then yelled at resident #16 for self-transferring, and the staff took his call light, water, and bedside table away, stating he wouldn't be bothering them anymore with getting up to urinate. NF2 stated that the CNA and nurse treated resident #16 like a criminal, and they shut his room door, so he could not get help if he needed it. NF2 stated the CNA and nurse were travel staff, and they were no longer working at the facility as far as she was aware. During an

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on interviews and record reviews, the facility failed to ensure residents were free from abuse and neglect, psychosocial harm, and deprivation of services, for 10 (#s 3, 4, 5, 6, 7, 12, 13, 14, 15, and 16) residents, out of 19 sampled residents. These failures contributed to three new wound areas for resident #3, several residents were left all night in urine-soaked briefs/bedding, were subjected to verbal abuse or neglect, #5 was left on the commode for an extended period of time, #12 was left unclothed and soiled, and was not assisted out of bed, #16 had items taken away from him and staff were verbally abusive after he fell, and residents filed grievances and were afraid to use their call lights. Findings include:1. During an interview on 12/2/25 at 8:47 a.m., resident #10 stated she overheard the CNAs come into the room and tell her roommate (resident #3) that they would not change her brief because she was just damp, and it was a lot of work to change her because she required a Hoyer (full body) lift for brief changes, over the weekend (11/29/25 - 11/30/25). During an observation and interview on 12/2/25 at 8:49 a.m., resident #3 was in her wheelchair, wearing a brief and gown. CNA staff were exiting her side of the room with the Hoyer lift. Resident #3 stated she was not consistently getting her check and changes done when needed over the weekend of 11/29/25 - 11/30/25. Resident #3 stated she had her call light turned on, and a CNA complained about the time a Hoyer lift took and that two staff were needed to use the Hoyer lift. Resident #3 stated the CNA left her in a wet brief all night on 11/30/25.Review of resident #3's weekly head-to-toe skin check, dated 11/26/25, completed by the wound nurse, reflected that resident #3 did not have skin breakdown on her medial thighs or intergluteal cleft. Review of resident #3's Skin Issues report, dated 12/3/25, reflected three new areas of moisture-associated skin damage were found. The following skin concerns were noted: - Resident #3 was identified to have a new skin issue on the right medial thigh, which was moisture-associated skin damage. It was due to Incontinence Associated Dermatitis. The wound was acquired in-house and was continuously painful and burning, per the resident. The nurse identified interventions included Relaxation techniques and barrier cream. The wound size was: Length (cm): 4.8 Width (cm): 0.3 Depth 0 (cm), and the description showed it had 100% granulation, and there was light exudate with a mixture of serous and sanguineous fluid that was typically pale, red, and watery. - Resident #3 was identified to have a new skin issue on the left medial thigh, which was moisture-associated skin damage. It was due to Incontinence Associated Dermatitis. The wound was acquired in-house and was continuously painful and burning, per the resident. The nurse identified interventions included Relaxation techniques and barrier cream. The wound size was: Length (cm): 1.8 Width (cm): 0.7 Depth 0 (cm), and the description showed it had 100% granulation, and there was light exudate with a mixture of serous and sanguineous fluid that was typically pale, red, and watery. -Resident #3 was identified to have a new skin issue in the intergluteal cleft, which was moisture-associated skin damage. It was due to Incontinence Associated Dermatitis. The wound was acquired in-house and was continuously painful and burning, per the resident. The nurse identified interventions included Relaxation techniques and barrier cream. The wound size was: Length (cm): 1.5 Width (cm): 0.2 Depth 0 (cm), and the description showed it had 100% granulation, and there was light exudate with a mixture of serous and sanguineous fluid that was typically pale, red, and watery.2. Review of a facility-reported incident, dated 11/10/25, reflected that staff members failed to provide care in accordance with professional standards. The report showed there were allegations that residents may not have received the necessary toileting, and they were not attended to in a timely manner. Three agency staff members may have provided substandard care during the shift. The report showed residents #3, 4, 5, and 13 were affected. Review of a grievance, dated 11/10/25, reflected that resident #3 filed a grievance about a CNA who yelled at her, and then the CNA threw a blanket on her. Resident #3 stated the CNA refused to get her a drink, and when she requested a nurse, the CNA was mean to her.During an interview on 12/2/25 at 8:42 a.m., resident #3 stated she needed help on 11/10/25, and the CNA refused to assist her with toileting and was not doing the resident check and changes. Resident #3 stated the CNA yelled at her, and resident #3 kicked the CNA out of her room.3. Review of a grievance, dated 11/10/25, reflected that resident #13 filed a grievance regarding care on 11/9/25. The grievance reflected the staff-to-patient ratio was unacceptable. The grievance went on to reflect that resident #13 was still in her pajamas at noon, and she waited for her call light to be answered for over an hour. The report showed her wound dressing was not dated, and resident #13 had a UTI. On the back of the grievance was a note that showed the DON had met with staff about wound care protocols. Staff members A and F had met with the family about what was being done during times of short

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, the facility failed to investigate and report to the State Survey Agency verbal abuse for 1 (#16) of 19 sampled residents. Findings include:During an interview on 12/2/25 at 3:07 p.m., NF2 stated she and her daughter both filed grievance forms regarding a fall for resident #16 on 11/10/25 and abuse by staff. NF2 stated resident #16 tried to brush his teeth and fell. The nurse and CNA then yelled at him for self-transferring, and took his call light, water, and bedside table away, stating he wouldn't be bothering them anymore with getting up to urinate. NF2 stated the CNA and nurse treated resident #16 like a criminal and shut his door so he could not get help if needed. NF2 stated the CNA and nurse were travel staff and no longer at the facility, as far as she was aware. During an interview on 12/2/25 at 3:25 p.m., staff member F stated staff member C received the grievance reports for resident #16. Staff member F stated that grievances related to abuse or neglect would normally go directly to staff member A for reporting.During an interview on 12/2/25 at 3:40 p.m., staff member A stated he had no knowledge of a fall for #16 or any grievances regarding resident #16. Staff member A stated he was not sure why he did not receive the grievances. The abuse was not reported to the State Survey Agency.During an interview on 12/3/25 at 12:35 p.m., staff member C stated she received the grievances for resident #16 on 11/10/25, and she and staff member F took them directly to staff member A.Review of a staff member statement, dated 12/3/25, reflected staff member R reported that the ADON said to her that the night nurse and CNA had verbally abused resident #16 after he fell and then took his water and call light away so he would not get back up and fall. Review of a staff member statement, dated 12/3/25, reflected staff member S had arrived for his shift and noticed the doors were closed for all of the residents who were a fall risk. When he went in to check on resident #16, resident #16 told him the nurse was mean to him and took his water and call light away, so he did not self-transfer or fall.Review of a staff statement, dated 12/3/25, reflected staff member C stated on 11/11/25 she had a meeting with the family of resident #16 who reported two staff members entered resident #16's room and yelled at him, What the F*** are you doing on the floor? and after putting him back in bed, the two staff members removed his bedside table, call light, and water, and stated, We will not be having any more issues/problems with you tonight and shut the door. Staff member C stated she reported the incident to staff member A. Review of the State Survey Agency reporting portal reflected that no Facility Reported Incident was sent in as required for this incident, until the surveyor brought it to the Administrator's attention.Review of the facility policy, Abuse, Neglect and Exploitation, dated 7/25/25, reflected:- . VII Reporting/Response-1. Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies within specified timeframes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interviews and record reviews, staff member B, a licensed nurse, failed to uphold professional standards of practice for nursing care, and falsified medical record documentation and health information related to resident treatments and monitoring, when she was not working in the facility to complete the tasks personally, for 10 (#s 3, 5, 7, 8, 9, 10, 11, 17, 18, and 19) of 19 sampled residents. Findings include:During an interview on 12/2/25 at 9:40 p.m., staff member T stated on the weekend of 11/29/25 - 11/30/25 it was difficult. Staff member T stated that due to a nurse calling off on 11/30/25, for a 12-hour day shift, one nurse was covering all of the 46 long-term care residents. Staff member T stated that staff member B was the admin on call and was notified. Staff member T stated that staff member B said she could not come into the facility to assist because she had her grandchildren, so she was charting in the resident's medical records from her home. Staff member T stated she reviewed the charting on the treatments in the TAR and found staff member B had charted treatments, assessments, and the monitoring of all of the long-term care residents, and some rehab residents, when she had not been in the building to complete those specific tasks. During an interview on 12/3/25 at 8:09 a.m., staff member U stated he was the only nurse for the long-term halls on 11/30/25 from 6:00 a.m. - 3:30 p.m. Staff member U stated staff member B never came into the building to assist him with the provision of nursing services. Staff member U stated he made sure the medications were given to the residents, and that the vitals were taken, but the monitoring and treatments were already checked off by staff member B. During an interview on 12/3/25 at 8:50 a.m., staff member D stated she suspected staff member B was falsifying charting for a while but had not had a chance to confirm this.During an interview on 12/3/25 at 12:35 p.m., staff member C stated she had received a concern from a nurse who stated staff member B had charted on her treatments and skilled charting when she was not in the building to complete the tasks. The nurse reported she was concerned because she could not complete her own charting as a result. Staff member C stated she did not think much of it and assumed staff member B had a reason for the charting.1. Review of resident #8's TAR, dated 11/1/25 - 11/30/25, reflected the following charting completed by staff member B on 11/30/25: Skilled note, elevate float heels, left foot: heel Medix lift on at all times, and TBP precautions.Review of resident #8's progress notes, dated 11/1/25 - 12/1/25, reflected that no skilled note or progress note was completed on 11/30/25.2. Review of resident #5's TAR, dated 11/1/25 - 11/30/25, reflected the following charting completed by staff member B on 11/30/25: Assess shortness of breath lying flat, monitor side effects of antidepressant, and monitor hours of sleep. Review of resident #5's progress notes, dated 11/1/25 - 12/1/25, reflected that no skilled note or progress note was completed on 11/30/25.3. Review of resident #3's TAR, dated 11/1/25 - 11/30/25, reflected the following charting by staff member B on 11/30/25: oxygen tubing storage, bipolar and depression monitoring, and monitor for personality dependent disorder symptoms.Review of resident #3's progress notes, dated 11/1/25 - 12/1/25, reflected that no skilled note or progress note was completed on 11/30/25.4. Review of resident #7's TAR, dated 11/1/25 - 11/30/25, reflected the following charting was completed by staff member B on 11/30/25: Skilled note required, daily blood pressures, and oxygen tubing storage.5. Review of resident #17's TAR, dated 11/1/25 - 11/30/25, reflected the following charting was completed by staff member B on 11/30/25: EBP, medications with milk, and nephrostomy wound care and monitoring. 6. Review of resident #9's TAR, dated 11/1/25 - 11/30/25, reflected the following charting was completed by staff member B on 11/30/25: daily vitals, EBP, insulin and hypoglycemic monitoring, pain assessment, skin care: bilateral feet, monitoring for paranoia, suspicion, accusatory behaviors, antidepressant side effects, anticoagulation monitoring, depression monitoring, and sleep monitoring. Review of resident #9's progress notes, dated 11/1/25 - 12/1/25, reflected that no skilled note or progress note was completed on 11/30/25.7. Review of resident #10's TAR, dated 11/1/25 - 11/30/25, reflected the following charting by staff member B on 11/30/25: Bilateral elevation of legs with positioning pillows, monitoring for episodes of anxiety, depressive symptoms, and side effects of antidepressants, Roho cushion placement in wheelchair and recliner.Review of resident #10's progress notes, dated 11/1/25 - 12/1/25, reflected that no skilled note or progress note was completed on 11/30/25.8. Review of resident #18's TAR, dated 11/1/25 - 11/30/25, reflected the following charting was completed by staff member B on 11/30/25: monitor for antidepressant side effects, left elbow: monitor Steri-strips and for signs of infection.9. Review of resident #19's TAR, dated 11/1/25 - 11/30/25, reflected the following charting by staff member B on 11/30/25: Monitor for insulin and hypoglycemic concerns, wound care: right second toe monitor for infection, monitor for behaviors, and monitor for diuretic

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interviews and record review, the facility failed to provide care for a resident, who was identified to be at risk for pressure ulcers, in accordance with her comprehensive person-centered care plan, and the resident's choice, and the resident had skin breakdown due to the lack of staff assistance for incontinence, for 1 (#3) of 19 sampled residents. These failures contributed to three new painful wound areas for resident #3. Findings include:. 1. During an interview on 12/2/25 at 8:47 a.m., resident #10 stated she overheard the CNAs come into the room and tell her roommate (resident #3) that they would not change her brief because she was just damp, and it was a lot of work to change her because she required a Hoyer (full body) lift for brief changes, over the weekend (11/29/25 - 11/30/25). During an observation and interview on 12/2/25 at 8:49 a.m., resident #3 was in her wheelchair, wearing a brief and gown. CNA staff were exiting her side of the room with the Hoyer lift. Resident #3 stated she was not consistently getting her check and changes done when needed over the weekend of 11/29/25 - 11/30/25. Resident #3 stated she had her call light turned on, and a CNA complained about the time a Hoyer lift took and that two staff were needed to use the Hoyer lift. Resident #3 stated the CNA left her in a wet brief all night on 11/30/25.Review of resident #3's weekly head-to-toe skin check, dated 11/26/25, completed by the wound nurse, reflected that resident #3 did not have skin breakdown on her medial thighs or intergluteal cleft. Review of resident #3's Skin Issues report, dated 12/3/25, reflected three new areas of moisture-associated skin damage were found. The following skin concerns were noted: - Resident #3 was identified to have a new skin issue on the right medial thigh, which was moisture-associated skin damage. It was due to Incontinence Associated Dermatitis. The wound was acquired in-house and was continuously painful and burning, per the resident. The nurse identified interventions included Relaxation techniques and barrier cream. The wound size was: Length (cm): 4.8 Width (cm): 0.3 Depth 0 (cm), and the description showed it had 100% granulation, and there was light exudate with a mixture of serous and sanguineous fluid that was typically pale, red, and watery. - Resident #3 was identified to have a new skin issue on the left medial thigh, which was moisture-associated skin damage. It was due to Incontinence Associated Dermatitis. The wound was acquired in-house and was continuously painful and burning, per the resident. The nurse identified interventions included Relaxation techniques and barrier cream. The wound size was: Length (cm): 1.8 Width (cm): 0.7 Depth 0 (cm), and the description showed it had 100% granulation, and there was light exudate with a mixture of serous and sanguineous fluid that was typically pale, red, and watery. -Resident #3 was identified to have a new skin issue in the intergluteal cleft, which was moisture-associated skin damage. It was due to Incontinence Associated Dermatitis. The wound was acquired in-house and was continuously painful and burning, per the resident. The nurse identified interventions included Relaxation techniques and barrier cream. The wound size was: Length (cm): 1.5 Width (cm): 0.2 Depth 0 (cm), and the description showed it had 100% granulation, and there was light exudate with a mixture of serous and sanguineous fluid that was typically pale, red, and watery.A review of resident #3's MDS, with an ARD of 11/30/25, showed she had a BIMS of 15; cognitively intact. She needed assistance with self care and was coded as being dependent for toileting. She required substantial to maximum assistance with her dressing, and needed assistance with rolling in bed. The resident was coded as being at risk for pressure ulcers, and she was marked as having unhealed pressure ulcers, the section for Moisture Associated Skin Damage was not marked. Review of resident #3's Care Plan, dated 9/5/25, reflected:- [Resident #3] is at risk for skin breakdown r/t impaired mobility and occasional incontinence. Interventions: . Provide thorough skin care after incontinent episodes and apply barrier cream.- . Incontinent of bladder . Interventions: . Assist to toilet at her requests, reminded as needed.- . [Resident #3] has physical functioning deficit related to: Mobility impairment, Self-care impairment, Weakness. Interventions: . TOILET TRANSFER: DEPENDENT She uses sit to stand lift, however, if she is fatigued a Hoyer can be used.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275080	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cooney Healthcare and Rehabilitation	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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275080	A. Building B. Wing	12/04/2025

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interviews and record reviews, the facility failed to have sufficient nursing staff available and working with the appropriate competencies and skills sets to provide nursing related services, taking the resident care needs and diagnoses of the facility's resident population into consideration, for 6 (#s 3, 5, 6, 10, 12, and 16) of 19 sampled residents. This deficient practice resulted in residents not receiving necessary ADL care and nursing services. Findings include:1. During an interview on 12/2/25 at 8:47 a.m., resident #10 stated she overheard the CNAs come into the room and tell her roommate (resident #3) that they would not change her brief because she was just damp (with urine) and it was a lot of work to change her because she required a Hoyer lift for brief changes. The Hoyer lift required two people to assist.During an interview on 12/2/25 at 8:49 a.m., resident #3 stated she was not consistently receiving the checks and changes for her brief use, when needed, over the weekend of 11/29/25 - 11/30/25. Resident #3 stated that staff complained about the time a Hoyer lift took, and that two staff members were needed to use the Hoyer lift. Resident #3 stated the CNAs left her in a wet brief all night on 11/30/25.2. Review of a facility reported incident, dated 11/10/25, reflected that staff failed to provide care in accordance with professional standards. The incident report showed residents may not have received toileting services, and they were not attended to in a timely manner. Three agency staff may have provided substandard care during the shift.3. During an interview on 12/2/25 at 8:42 a.m., resident #3 stated she needed help on 11/10/25, and the CNA refused to assist her with toileting and was not doing check and changes (brief checks/changes). 4. Review of a facility reported incident, dated 11/3/25, reflected resident #6 was not being properly turned and repositioned as required, resulting in the resident being found wet with urine and in need of a full bed linen change. During an interview on 12/1/25 at 3:11 p.m., resident #6 stated she did not get checked or changed when staff member M worked last, and she was wet all night.During an interview on 12/2/25 at 8:29 a.m., resident #5 stated that staff member M helped her to the toilet, but then she never came back. Resident #5 waited a long time on the toilet and had to finally get herself back to her bed on her own. 5. Review of a grievance, dated 11/10/25, reflected that resident #12 complained a CNA left her in bed naked and covered in urine and feces overnight. During an interview on 12/3/25 at 1:30 p.m., resident #12 stated the CNA left her sitting in urine and feces all night. Resident #12 stated the CNA changed her in the morning and then left her in bed naked. Resident #12 stated the CNA was supposed to get her up but did not.During an interview on 12/2/25 at 9:45 a.m., staff member Q stated she had several complaints regarding the travel/agency staff and call-offs. Staff member Q stated on 10/20/25, a travel CNA walked out on her shift, resulting in residents complaining. On 11/9/25, a core (non-agency) CNA walked out on his shift, and that night two agency staff abused a resident. Staff member Q stated on 11/30/25 that a nurse call-off resulted in complaints. Staff member Q stated that the staff's orientation to the building only happened if she was working, but no skills checklist was completed at the facility for travel agency staff. Staff member Q stated that the agency they contracted with completed the skills checklists with their staff.During an interview on 12/2/25 at 9:40 p.m., staff member T stated the weekend of 11/29/25 - 11/30/25 was difficult. Staff member T stated that due to a nurse call off on 11/30/25, which was for a 12-hour day shift, one nurse was covering all of the 46 long-term care residents. Staff member T stated staff member B was the admin on call and was notified. Staff member T stated staff member B stated she could not come in to assist because she had her grandchildren. Staff member T stated staff member B repeatedly stated she was on her way, when she dropped the grandchildren off, but she never came in. Staff member T stated she told her staff to prioritize residents who needed frequent brief changes, and the other residents would need to wait for care. Staff member T stated staffing on the nights and weekends was regularly short (less available) due to call offs, and rarely did management assist by coming in and working. Staff member T stated the facility relied heavily on travel staff and provided them with little to no orientation or training. Staff member T stated she frequently found herself as the only core staff with all others in the building being travelers. She stated she spent so much time orienting and answering questions for them that she was unable to complete her own nursing duties. During an interview on 12/2/25 at 9:59 p.m., staff member V stated she had worked at the facility for the last five or six nights and had no orientation or training for the facility. Staff member V stated she had fumbled through the tasks for the first few nights until she could find her way around and learn the residents. Staff member V's lack of orientation to the facility's policies and procedures hindered her ability to complete her duties. During an interview on 12/3/25 at 8:09 a.m., staff member U stated he was the only nurse for the long-term halls on 11/30/25 from