

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 12/31/2025
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure baseline care plans were completed within 48 hours, to meet the residents' ADL needs, for 2 (#s 20 and 21) of 25 sampled residents. This deficient practice resulted in a delay in ADL cares for residents #20 and 21. Findings include:1. During an interview and observation on 12/30/25 at 4:32 p.m., resident #20 was lying in bed with family at the bedside. Resident #20 stated staff member R told her she needed to walk without her walker or the use of a gait belt over the weekend (12/27/25-12/28/25). Resident #20 stated she was not cleared by therapy to walk without a gait belt and walker. Review of resident #20's baseline care plan, revised 12/30/25, reflected that resident #20 was admitted on [DATE] and did not reflect the ADL care needs for walking, toileting, transfers, bathing, or eating. During an interview on 12/30/25 at 4:55 p.m., staff member S stated a gait belt and four-wheeled walker should have been used during any transfers or walking over the weekend of 12/27/25 - 12/28/25, per the therapy evaluation.During an interview on 12/31/25 at 10:05 a.m., staff member R stated he had received a report from the previous shift that resident #20 was not using any assistive devices. Staff member R stated he did encourage resident #20 to walk without the walker and gait belt because he was told she did not need them during the shift report.2. During an interview on 12/30/25 at 2:58 p.m., NF1 stated she came in on 12/25/25 to pick up resident #21 for the holiday. NF1 stated resident #21 was still in bed, wearing day clothes, not pajamas, was soaked in urine, and was told there was no shower room available at the moment. Review of resident #21's baseline care plan, last revised on 12/29/25, reflected resident #21 was admitted on [DATE] and did not reflect the ADL care needs for walking, toileting, transfers, or bathing.During an interview on 12/31/25 at 8:02 a.m., staff member B stated resident #20 and 21's baseline care plans were not completed and did not include the resident's ADL care needs. Staff member B stated the admitting nurse should have completed the baseline care plans at the time of admission.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on interviews and record review, the facility failed to provide ADL cares to meet the needs of dependent residents for 2 (#s 20 and 21) of 25 sampled residents. This deficient practice resulted in resident #20 fearing her safety during transfers and walking and resident #21 to be found by family wet and still in bed at 12:30 p.m. Findings include:1. During an interview on 12/30/25 at 4:32 p.m., resident #20 stated staff member R told her she needed to walk without her walker or gait belt over the weekend (12/27/25-12/28/25). Resident #20 stated she was not cleared by therapy to walk without a gait belt and walker. During an interview on 12/30/25 at 4:55 p.m., staff member S stated a gait belt and four-wheeled walker should have been used during any transfers or walking over the weekend of 12/27/25-12/28/25 per the therapy evaluation. During an interview on 12/31/25 at 10:05 a.m., staff member R stated he did encourage resident #20 to walk without the walker and gait belt because he was told she did not need them during shift report.Refer to F655 - Baseline Care Plans, for concerns related to the lack of information available on the resident care plan for #20. 2. During an interview on 12/30/25 at 2:58 p.m., NF1 stated she came in on 12/25/25 to pick up resident #21 for the holiday and resident #21 had not received the necessary ADL care that morning. Review of a statement by Staff member T, dated 12/29/25, reflected resident #21 was very sleepy and not waking up, so she let her sleep. Staff member T stated she had been told during shift report that resident #21 had a rough night (not sleeping well) and thought that was the reason for her sleepiness. Staff member T stated she was upset with herself when the family came in and was upset. Staff member T stated she should have been more aggressive in waking up resident #21 and toileting her. Refer to F655 Baseline Care Plans for resident #21.</p>