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	09/11/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure pressure ulcer wounds were identified, closely monitored, treated, and prevented so they did not develop in the facility or worsen; and, it was found pressure wounds were not treated per the physician orders; the wound care nurse was not informed of new wounds, failed to follow safe infection control processes during wound care, or have the necessary skillset for wound care services and oversight of the wound program; licensed nursing staff were documenting wound care was completed when not done; nursing staff failed to reposition residents with wounds as needed; and the cumulative effect of this failure was the wound development or wound worsening for 4 (#s 2, 6, 8 and 9), of 7 residents sampled for wounds. Resident #2 had a Stage II wound that developed in-house. Resident #6 had two Stage II pressure ulcer develop in the facility. Resident #8 was on hospice and had a Stage I pressure ulcer that worsened into a Stage II pressure ulcer with six new deep tissue injuries located on both buttocks. Resident #9 had a Stage II wound, and the wound care nurse was not aware of the wound. This failure significantly increased the risk of worsening wounds or for more wounds to develop on any resident who had wounds or was at risk for wounds. Findings include: 1. Wound care oversight, lack of training, and resident #9: During an interview on 9/10/25 at 8:14 a.m., staff member F stated they were new to the wound care position and had no prior experience. Staff member F also stated they were not certified as a wound care nurse yet. Staff member F stated they acted as a wound care nurse on Wednesdays; all other days of the week, the floor nurses were expected to complete the wound care dressing changes by following the physician's orders. Staff member F stated being unaware of any wounds with resident #9, who had documentation of a Stage II pressure ulcer. Staff member F stated, That's also a work in progress, as to how staff member F got notified of new wounds from the floor staff. Staff member F stated that sometimes the staff will tell her directly, text her, or there is a box outside of the administration's office where floor staff can notify someone. Staff member F also stated being new to the position, many staff members did not know who staff member F was yet. Staff member F stated this process (the wound care system) was not perfect yet, and many areas within the system still needed improvement to ensure there closed-loop communication between staff member F, the floor staff, and the administrative staff.During an interview on 9/10/2025 at 4:10 p.m., staff member F stated they would have never known about resident #9's Stage II pressure ulcer if the surveyor had never notified them of it. Staff member F stated the floor staff nurse who discovered it should have notified the administrative staff or staff member F, and should have notified a physician to obtain wound care orders. Staff member F stated it was hard for them to do wound care on a resident they did not even know had a wound. 2. Resident #2:During an observation on 9/10/25 at 9:24 a.m., staff member F was completing a wound care dressing change on resident #2. Staff member F removed an old silicone foam sacral dressing, and staff member F stated the previous dressing was not signed or dated, which made it difficult to determine when the dressing was last changed. Staff member F also stated there was no residual zinc ointment (Triad) on the skin, which indicated the previous nurse did not follow the physician's orders. Staff member F stated all of the floor staff had access to the necessary wound supplies in their own carts, but if they needed anything specific, the floor staff also had easy access to the wound care cart. Review of (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident #2's EHR showed the physician order, revised 8/21/25, which included: Wound Care: Stage I pressure wound sacrum 1. Clean with saline. 2. Triad 3. Sacral foam 3x weekly or PRN if soiled.3. Resident #6:During an observation and interview on 9/10/25 9:51 a.m., staff member F dressed resident #6's wound to the left and right buttocks. Staff member F stated this was a Stage II pressure ulcer as the first layer of skin was missing, but there was no subcutaneous tissue observed. An observation of the wound showed similar findings to what staff member F described, as the first layer of the skin was gone, leaving a light pink wound bed below on the bilateral buttocks. Staff member F stated (on 9/10/25 at 8:14 a.m.) that resident #6 was new for her and on the wound list as of 8/27/25, and the wound had not been open the last time staff member F observed the wound. Therefore, the wound was worsening.Review of resident #6's EHR showed the physician order, dated 8/28/25: Wound Care: Redness right buttock 1. Triad cream. There were no physician orders concerning the left buttock wound.4. Resident #8:During an observation and interview on 9/9/25 at 1:07 p.m., resident #8 stated her buttock area hurt all the time. She stated her buttock hurt at a 10/10 pain when using the zero to ten pain scale. She stated the staff members would not reposition her regularly.During an observation and interview on 9/10/25 at 10:13 a.m., staff member F removed resident #8's left ear bandage, which showed the bandage was last changed by staff member F on 9/3/25 (a week prior). Staff member F stated the floor nurses were not following the physician's orders because the initials on the bandage were staff member F's, and this dressing should have been changed every other day. Staff member F then turned on the light above resident #8's bed and removed resident #8's right ear dressing. Staff member F also touched the wound care Ipad and Healx stickers with the soiled gloves. No hand hygiene was performed between these tasks. Staff member F stated the resident's right ear dressing had been last changed by them as well on 9/3/25. They stated these dressings should have been changed multiple times before the staff member F coming in the next week. Then, staff member F stated resident #8 had six new deep tissue injury wounds to her buttock area that were not present last week. Staff member F stated these areas could be from moisture, shearing, and pressure, but due to resident #8's catheter, moisture was slightly less of a concern. Staff member F stated the facility should be turning the resident at least every two hours as she was on hospice and had a pressure ulcer. Staff member F stated they tried to make sure there were orders in for dependent residents for repositioning every two hours. Staff member F stated that repositioning should be a standard practice for CNAs and nurses, but an order was a good idea for the dependent residents. Staff member F stated the facility should probably be turning her every hour. During the dressing change, staff member F took off the old dressing and touched the Ipad, Healx stickers, and clean supplies located in the wound cart without doffing gloves or performing hand hygiene first. Staff member F later applied the triad cream to resident #8's coccyx after the surveyor had pointed out the ointment had been missed, and staff member F had doffed gloves, performed hand hygiene, and was getting ready to leave the room.Review of resident #8's EHR showed a physician's order: . Sacrum stage 1 pressure. Cleanse with NS. 2. Apply triad cream . [sic]Review of resident #8's EHR showed a physician's order showed the bilateral ear dressings needed to be changed every other day.Review of resident #8's EHR showed on the TAR for on 9/5/25 and 9/7/25, resident #8's bilateral ear dressings were documented as completed, although the surveyor observed the dressing on the resident's ear dated 9/3/25. During an interview on 9/10/25 at 1:30 p.m., staff member FF stated the skin breakdown noted on resident #8's buttock area was due to pressure and a lack of repositioning. Staff member FF stated there should be physician orders that the facility could put in concerning repositioning. Staff member FF stated the staff could do something as simple as micro shifts that would relieve pressure and not wake up a resident or cause them any pain.5. No positioning for resident #8 leading to further skin breakdown:Review of resident #8's EHR showed hospice was initiated for resident #8 on 4/29/25, and completely dependent on staff for repositioning and skin care.Review of resident #8's EHR showed a facility task for the past 30 days which included: . Roll left and right: The ability to roll from laying on back to left and right side, and return to laying on (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	back on the bed. [sic] Resident #8 was Dependent . or required Substantial/maximal assistance . 26 out of 30 opportunities documented.The following observations below, from 9/8/25 to 9/9/25, where resident #8 was laying directly on her back, showed no positioning devices or pillows were in use to offload resident #8 from her coccyx:-9/8/25 at 11:03 a.m.,-9/8/25 at 3:44 p.m.,-9/8/25 at 8:17 p.m.,-9/8/25 at 8:50 p.m.,-9/9/25 at 8:30 a.m.,-9/9/25 at 1:02 p.m.,-9/9/25 at 1:21 p.m.; and,-9/9/25 at 2:13 p.m.During an observation on 9/9/25 at 2:21 p.m., staff members assisted resident #8 up with a lift to change her bedding. Resident #8 was back to bed by 2:49 p.m., lying directly on her back, without any pillows or positioning devices, supporting the resident's positioning on either side of the body. During an observation on 9/9/25 at 3:27 p.m., staff member F stated the staff members rotated the dependent residents every couple of hours, side to side. Staff member F stated documentation for repositioning was located in the TAR for the nurses and was a basic skill learned in nursing and CNA school.The following additional observations were made from 9/9/25 to 9/10/25, where resident #8 was lying directly on her back with no positioning devices or pillows in use to offload resident #8 from her coccyx:-9/9/25 at 3:30 p.m.,-9/9/25 at 3:51 p.m., -9/9/25 at 4:20 p.m.,-9/10/25 at 8:10 a.m.,-9/10/25 at 8:45 a.m., and-9/10/25 at 10:13 a.m., resident #8 was turned for wound care at this time.During an interview on 9/10/25 at 8:14 a.m., staff member F stated every resident who was on hospice or had any pressure ulcers should have a physician order to reposition the resident every two hours. Staff member F stated, pressure, any shearing forces, Hoyer lifts, moisture, and any trauma (such as from a fall, or adaptive equipment) could contribute to or worsen a pressure ulcer. Staff member F stated the facility should assess pain and could use positioning wedges to help with positioning.During an interview on 9/10/25 at 3:55 p.m., staff member CC stated repositioning was a basic skill that both CNAs and Nurses should know. Staff member CC stated the facility staff could benefit from more of a check off system on the MAR as there was only a twice-a-day reminder on the TAR. Staff member CC stated many of the nurses would only look at the TAR towards the end of the shift. Staff member CC stated the CNAs could benefit from a paper check off system for repositioning.During an interview on 9/10/25 at 8:05 p.m., staff member BB stated they felt low staffing numbers contributed to residents not being repositioned. Staff member BB stated, Oh, there is definitely not enough staff for repositioning, most of the time it never gets done, so yeah staffing is my main concern working at this facility. Refer to F725 for further information on staffing.Review of a facility policy, titled Turning and Repositioning, dated 6/10/25, showed, . 1. All residents at risk of, or with existing pressure injuries, will be turned and repositioned . 3. A routine turn schedule includes both side-lying and back positions, alternating from the right, back, and left side.Review of residents #2, #6, and #8's EHRs and Weekly Wound Assessments showed these wounds were In-House Acquired.

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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. Based on observation, interview, and record review, the facility failed to ensure a resident who left the facility unattended was monitored and supervised sufficiently for elopement prevention, and the resident left the facility again, unattended and without staff knowledge, for 1 (#6) of 26 sampled residents, and resident #6 sustained minor injuries when he had a fall. Staff failed to follow the identified safety interventions for elopement prevention, and the facility classification of an elopement allowed the resident to exit the facility and be in an unsafe environment unattended. Findings include: Review of resident #6's EHR showed a nursing note, dated 8/20/25, which included, This nurse called on call provider. due to patient continuing with extreme agitation and anxiety regarding the earthquakes he has been talking about all night.Review of resident #6's EHR showed an IDT Event Review note, dated 8/20/25, which included, . alerted nurse that resident was located walking parking lot. Resident seemed frustrated that an earthquake was happening, and he needed to get to safety. Resident has a small laceration on index finger . 30 minute rounding started at 3:$5 am (sometime around 3:00 a.m.). [sic] There was no other documentation showing any details as to what occurred that night or how the resident had gotten out of the building.Review of resident #6's EHR showed a nursing note, dated 8/31/25, . 0048 (12:48 a.m.) is when resident was noticed to be missing . CNA alerted this RN that resident was no longer in the dining room. After searching the facility, resident was unable to be located. Resident was returned to the facility at 0124 (1:24 a.m.). During this incident, resident #6 fell and had a scrape to his right forearm and reported right hip pain. The facility later sent resident #6 for an x-ray to rule out a broken hip. Both incidents on 8/20/25 and 8/31/25 resulted in resident #6 getting out of the facility and resulted in an injury to resident #6, The event on 8/31/25 was reported to the State Survey Agency. During an observation and interview on 9/8/25 at 11:33 a.m., staff member GG was sitting in resident #6's room and stated that resident #6 was on a 1:1 staff-to-resident watch as the resident had eloped in the past.During an observation and interview on 9/8/25 at 8:04 p.m., the facility's front doors were unlocked. Staff member H stated the facility's front doors were never locked or expected to be locked until that night. Staff member H stated that night, they were unlocked because staff called administration and asked for the doors to stay open until 9:30 p.m., as there was a family member staying until that time.During an observation on 9/8/25 at 8:50 p.m., resident #6 did not have a 1:1 sitter with him.During an observation on 9/9/25 at 8:31 a.m., resident #6 did not have a 1:1 sitter with him. During an interview on 9/9/25 at 1:04 p.m., staff member GG stated last night they did not have another staff member available to give report for a 1:1 sitter with resident #6, so there was no sitter last night. Staff member GG stated staff was responsible for watching resident #6 24/7 to ensure he did not elope and would document this on the paper in the resident's room.During an interview on 9/9/25 at 1:14 p.m., staff member DD stated resident #6 was an elopement risk and was on 1:1 and 15-minute checks by staff member DD. They stated resident #6 was on 15-minute checks, and if the resident was showing any behaviors or was exit seeking, then the resident would be 1:1 at that time. Staff member DD stated all of the nurses and CNAs communicated this to one another, and this was how all staff were notified. Staff member DD stated prior to the elopement on 8/31/25, resident #6 did show signs of wandering, even though he had left the facility previously. Staff member DD stated they were able to keep track of the 15 minutes by their timer on their watch(s). During an observation on 9/9/25 at 2:06 p.m., staff member DD was observed in the rehab department and giving showers to other residents.During an observation on 9/9/25 at 2:33 p.m., staff member DD was not in resident #6's room, and resident #6's 15-minute check sheet had not been documented on since 2:15 p.m.During an observation on 9/9/25 at 2:40 p.m., staff member DD had not been in resident #6's room since 2:33 p.m. and there was no documentation for the 15-minute checks since 2:15 p.m. During an observation on 9/9/25 at 2:49 p.m., staff member DD returned to resident #6's room. During an observation and record review on 9/9/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at 2:59 p.m., resident #6's 15-minute check documentation showed staff member DD was in resident #6's room at 2:30 p.m. and 2:45 p.m. However, staff member DD had not been in resident #6's room for 34 minutes, as observed by this surveyor. During an interview on 9/9/25 at 3:04 p.m., staff member G stated resident #6 had eloped and had fallen outside. Staff member G stated this was probably the reason the front door was locked now. Staff member G stated the 15-minute checks were news to them, but assumed one staff member would check on resident #6 every 15 minutes, and an additional staff member would be 1:1 with resident #6. Staff member G was very unclear to how the facility would have both 1:1- and 15-minute checks at the same time. They assumed a nurse would tell them in report. Staff member G stated resident #6 did not sleep well, and this could explain why he wandered at night. Staff member G stated they felt resident #6 would benefit from a Wanderguard as he did wander around the building.During an interview on 9/10/25 at 11:11 a.m., staff member E, stated there had been a change in resident #6's baseline cognitive status, and said he used to ask staff to take him outside as he liked to go outside very frequently. Staff member E stated the night of 8/31/25, a night shift staff member had last seen resident #6 in the dining room around 11:30 p.m. or 12:00 a.m. Staff member E stated resident #6 was not found until hours later. Staff member E stated the facility used to have Wanderguards, but that was more than a year ago, and stated there were other residents who also wandered and who got out of the facility as well. Staff member E stated resident #6 had gotten out of the facility twice. Staff member E stated they had no idea why the front doors were not locked after the first time resident #6 had gotten out of the building. Staff member E stated the doors were locked, preventing entry but not exit.During an interview on 9/10/25 at 11:24 a.m., with staff members A and C, staff member A stated resident #6 eloped on 8/31/25, and this incident was reported to the State Survey Agency. Staff member A stated resident #6 was being checked by a staff member every 15 minutes. Both staff members A and C stated when resident #6 had left the faciity on 8/20/25, and found in the parking lot, this was not considered an elopement. Staff member A stated the facility had changed their policy where the company would not consider a resident eloping if the resident was on the facility's grounds. Staff member A stated that with the incident on 8/20/25, resident #6 was still in the facility's parking lot, and staff member A stated the parking lot was still considered the facility's space. Staff member A stated resident #6 had made it 1.1 miles away from the facility on 8/31/25, where he then fell. Staff member A stated resident #6 was a 1:1 from 8/31/25, which then ended Monday morning. Staff member A stated the facility was in the process of getting a Wanderguard system put in. Staff member A stated the Wanderguard system was not put in sooner because a conversation was made with the physicians regarding all of the residents in the facility, and no residents were deemed as an elopement risk. During an interview on 9/10/25 at 11:45 a.m., staff member EE stated the facility was in the process of getting a Wanderguard put in. Staff member EE stated a Wanderguard would be smart because there were a couple of residents who liked to wander outside, specifically stating resident #6 was one. Staff member EE stated it was a good thing that the doors were locked now, but stated a resident could still exit the doors from the inside.During an interview on 9/10/25 at 12:01 p.m., staff member P stated the front door was watched from the normal business hours but was not watched after that time. Staff member P stated, To me it does feel unsafe (to have the front door unlocked). Staff member P, stated, I want them (the residents) to be safe. They are like our family. Staff member P stated the staff members created a bond with the residents. Staff member P stated the facility would consider a resident to have had eloped if they got to the end of the walkway or passageway. Staff member P stated, Personally, (I would not be comfortable with them going that far) not even that far. Staff member P stated they felt a resident would be unsafe if they got out of the facility for safety reasons because many of the residents were confused, a resident could get into an unknown vehicle, the resident could fall, or the resident could get hit by a car.During an interview on 9/10/25 at 3:52 p.m., staff member II stated the facility could not do both 1:1 and 15-minute checks. Staff member II stated it did not make any sense for the same person to do those two tasks at the same time. During (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	an observation and interview on 9/10/25 at 8:01 p.m., staff member II opened the front door of the facility from the inside. No keys or code was needed to open the door. Staff member II stated this was normal for this door to open from the inside, but to be locked from the outside.During an interview on 9/10/25 at 8:00 p.m., staff member K stated, Staffing is terrible here at night. We need more help to answer all the call lights. We have several dementia patients wandering all night, multiple two-person Hoyer patients, and only three CNAs.During an interview on 9/10/25 at 8:03 p.m., staff member J stated, We only have three CNAs in the building; we can't keep track of all these residents, much less the elopers.During an interview on 9/10/25 at 8:06 p.m., staff member JJ stated being assigned to the 1:1 with resident #6, and staff member JJ also had to verify #6's location every 15 minutes.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, interviews, and record review, the facility failed to ensure that timely pain management was provided for a resident who was exhibiting significant pain that was reportedly unbearable. consistent with professional standards of practice, for 1 (#11) of 26 sampled residents. Findings include:During an observation and interview on 9/8/25 at 2:49 p.m., resident #11 was lying in bed, holding his left wrist, wincing in pain. Resident #11 stated he was in 8/10 pain in his left wrist. Resident #11 stated he had carpel tunnel in the left wrist, and the pain was unbearable. Resident #11 stated he was only given Tylenol for his pain, and it was not helping. Resident #11 stated the nurse was aware of his pain. Resident #11 stated he received oxycodone for peripheral neuropathy twice a day.During an observation and interview on 9/8/25 at 8:06 p.m., resident #11 was lying in bed, holding his wrist and stated his left wrist pain was a 9/10 and moving up his arm. Resident #11 had a large area of swelling on the top of his hand and swelling around the wrist.During an interview on 9/9/25 at 10:25 a.m., staff member F stated resident #11 had been in pain for the last couple of days. Staff member F stated she reached out to the physician yesterday and had not received a response. Staff member F stated she reached out to the physician's office again this morning and was told the resident would be seen on 9/11/25. No orders were given for pain management. Staff member F stated she was frustrated by the difficulty she was having with responses from the physician's office and had no other options for pain management until the physician could see resident #11.During an interview on 9/9/25 at 10:45 a.m., with staff member C and F, staff member C stated the nurse should reach out to the Director of Nursing if she felt she was not getting the response she needed for the residents. Staff member C stated she would have resident #11 seen by the physician today.Review of resident #11's Visit Summary Order, dated 9/9/25 was later received for resident #11 to be seen in the urgent care for x-rays of his wrist. Resident #11 returned with a wrist splint. Resident #11's x-ray showed no fractures.During an observation and interview on 9/10/25 at 8:19 p.m., resident #11 was lying in his bed holding his arms above his head and floating both arms up in the air. Resident #11 had an ice pack under his neck/shoulders. Resident #11 stated, I'm sick as hell, I have so much neck pain. The wrist has now worked all the way up to my neck. It's a 9/10, I can't even move. The nurse entered the room and stated she would be giving him an oxycodone to help with his pain.Review of resident #11's care plan, dated 8/13/25, did not reflect resident #11 had pain in his wrist or carpel tunnel. Review of the facility's policy, Pain Management, dated 5/1/25, reflected:- The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goal and preferences.

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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. Based on interview and record review, the facility failed to have sufficient staff to meet the needs of the residents for 3 (#s 2, 11, and 54) of 26 sampled residents. Findings include:1. During an interview on 9/8/25 at 4:09 p.m., resident #2 stated the facility could get so short staffed that she would have to wait as long as 45 minutes to receive help. She stated if she waited too long she would go to the restroom without a staff member because she could not wait any longer. During an interview on 9/9/25 at 7:54 a.m., resident #2 stated staffing was awful and weekends were the worst. Resident #2 stated pain medications were late, and no one answered the call lights when help was needed at night or on the weekends. Resident #2 stated this facility was the worst she had been to, and she even had to insist on having her sheets changed because they had not been changed in weeks. Resident #2 stated the facility needed more help. 2. During an interview on 9/8/25 at 2:53 p.m., resident #11 stated he had several incontinence incidents since his admission because staff do not assist timely to the toilet. Resident #11 stated CNAs would come in during the night and turn off the call light and state they would return to help him but never returned. Resident #11 stated he had bowel movements in his bed as a result. Resident #11 stated it often took move than 30 minutes to get assistance when he needed to use the toilet. Resident #11 stated he was normally continent of both bowel and bladder and found the incontinence episodes to be . humiliating and frustrating. Review of resident #11's Care Plan, dated 8/13/25, reflected resident #11 required moderate to substantial assistance with toileting. During an interview on 9/9/25 at 10:25 a.m., staff member F stated she had heard from resident #11 and his wife that resident #11 had a few bowel movements in his bed on night shifts. Staff member F stated the day shift did not have any trouble meeting his call light needs, and he had not had bowel movements in his bed during her day shifts. Staff member F stated resident #11 was continent of bowel and bladder so long as he had assistance to the toilet. During an interview on 9/10/25 at 3:15 p.m., staff member E stated she regularly received complaints on Mondays and at care conferences from residents and families about weekend staffing, showers, and call light times. Staff member E stated she immediately reported these concerns to the Administrator. During an interview on 9/10/25 at 8:00 p.m., staff member K stated, Staffing is terrible here at night. We need more help to answer all the call lights. We have several dementia patients wandering all night, multiple two-person Hoyer patients, and only three CNAs. During an interview on 9/10/25 at 8:03 p.m., staff member J stated, We only have three CNAs in the building; we can't keep track of all these residents, much less the elopers. During an interview on 9/10/25 at 8:05 p.m., staff member BB, stated she did not feel the staffing was safe, especially when the 6-10 p.m. float nurse left early, then stated, Like tonight, she left at 7:15 p.m., and it happens a lot. Staff member BB stated she did not like to be put in those kinds of situations because it was not safe for residents. Staff member BB stated management rarely comes in to help, then stated, They know we are short tonight and no help. Staff member BB stated she (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	answered call lights within 60 seconds, even if she must go to a hall she was not covering, while some staff will ignore lights, then stated, Some staff ignore lights even if they are standing right next to a room, that's alarming. Staff member BB stated, Oh there is definitely not enough staff for repositioning, most of the time it never gets done, so yeah staffing is my main concern working at this facility. 3. During an interview on 9/8/25 at 11:05 a.m., resident #54 stated the facility was so short handed and she had to wait a while for help sometimes. Resident #54 stated that sometimes she had to wait a long time for a staff member to bring her pain medication. She stated, I've had it where they're really short and it felt like an hour. During an interview on 9/10/25 at 3:55 p.m., staff member CC stated residents were not getting repositioned due to low staffing numbers and weekends and night shifts were known to be the worst shifts for low staffing. During an interview on 9/10/25 at 8:06 p.m., staff member JJ stated the facility did not have the staff to provide enough care, especially at night. Staff member JJ stated, There's not enough of us to go around. Staff member JJ also stated there was not enough staff to consistently turn and reposition the residents every two hours.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observations, interviews, and record review, the facility failed to ensure a registered nurse was on duty for at least eight consecutive hours a day, seven days a week. Findings include:Review of the facility's CASPER PBJ Staffing Data Report dated 1/1/25-3/31/25, reflected: -The facility reported no registered nursing hours for 1/4/25, 1/5/25, 1/19/25, 1/25/25, 1/26/25, 2/15/25, 2/16/25, 3/2/25, 3/9/25, 3/15/25, 3/16/25, 3/22/25, and 3/23/25. Review of the facility provided time punches for the dates listed above reflected the [NAME] PBJ data report was accurate. During an interview on 9/10/25 at 1:10 p.m., staff member A stated he thought maybe the director of nursing covered the shifts in question, but he no longer worked at the facility. Staff member A stated he reviewed medication administration and notes but was unable to confirm the director of nursing worked the shifts in question. Review of facility provided, Census vs Budget, dated April 2025 - June 2025, reflected the average daily census was 66.76. Review of the facility's policy, Nursing Services and Sufficient Staff, dated 5/13/25, reflected: - . 3. The facility is required to provide licensed nursing staff 24 hours a day .8. the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.9. The Director of Nursing may serve as a charge nurse only when the facility has an average daily census occupancy of 60 or fewer residents. [sic]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control measures were implemented during the transportation of dirty laundry to prevent transmission of communicable diseases, and failed to ensure enhanced barrier precautions and aseptic technique were followed while performing a wound dressing change for 3 (#s 2, 8, and 53). Findings include: 1. During an observation and interview on 9/10/25 at 1:01 p.m., staff member AA was observed rolling a dirty laundry cart from the laundry room on the first floor to the basement, while touching three different doorknobs and one push-button door code, all while wearing the same soiled gloves, and without hand hygiene. Staff member AA stated it was hard to transport dirty laundry to the basement since the elevator broke in October of 2024 and stated she does not know when it is going to be fixed. Staff member AA stated, We need to improve our infection control; I don't like that my dirty gloves are touching everything. We should be better. During an interview on 9/11/25 at 8:03 a.m., staff members B, C, and D stated staff member AA came and spoke with them on 9/10/25 about her concerns regarding transporting dirty linens with hand hygiene related to being in compliance, and stated, We need to add hand hygiene to our list (of topics to work on). 2. During an observation on 9/10/25 at 9:24 a.m., staff member F did not perform hand hygiene or follow enhanced barrier precautions (no gloves or gown were donned) when entering resident #2's room for a wound care dressing change. Staff member F brought the wound care cart into resident #2's room and did not clean the cart or surface of the cart after exiting the room. During the wound dressing change, staff member F took off resident #2's old silicone foam sacral dressing and then touched the wound care Ipad with the same gloves. Staff member F also touched the wound care cart drawers, the contents within the drawers to get clean wound supplies, and the Healx sticker packaging (a tool used to assist with a wound measurement when using the wound care Ipad). Staff member F took a photo of resident #2's coccyx wound and then placed the Ipad back on the wound care cart. Staff member F then removed the gloves, performed hand hygiene, then donned new gloves. Staff member F grabbed the clean supplies (gauze, cleanser, sacral foam, and zinc) that had been previously touched by the soiled gloves and placed a new dressing on resident #2's coccyx. 3. During an observation on 9/10/25 10:13 a.m., staff member F entered resident #8's room without performing hand hygiene and did not follow enhanced barrier precautions as no gown or gloves were donned. The wound care cart was brought into resident #8's room. Staff member F first removed resident #8's left ear dressing, then touched the overhead light above resident #8's bed with the same gloves. Staff member F then touched the following items with the same dirty gloves: the wound care Ipad, the Healx stickers, an adhesive remover which was located inside of the cart, and all of the supplies resident #8 required for her new dressings which were located inside of the wound care cart. 4. During an observation on 9/9/25 at 10:49 a.m., staff member F prepared to provide wound care for resident #53's wounds. Resident #53 was lying on his side. Staff member F put on gloves, cleansed the wound on resident #53's sacrum, placed the dressing, and degloved. Staff member F put on new gloves from her pocket, cleansed resident #53's right knee wound, went into her supply cart for a bandage, dated the bandage, and placed the bandage on the knee. Staff member F degloved and put on new gloves. Staff member F assessed a new wound on resident #53's right great toe, used betadine to cleanse the wound, and degloved. Staff member F put on new gloves and collected supplies from her cart. Staff member F cleansed the wound on resident #53's right ankle, took a picture with the Ipad, and then placed the new dressing on the wound. Staff member F failed to used (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hand sanitizer between glove changes and did not change gloves between dirty and clean tasks. During an interview on 9/9/25 at 11:45 a.m., staff member F stated she just did not think about changing gloves when all the wound care was for the same resident. Staff member F stated she had not had any formal training on wound care. During an interview on 9/11/25 at 8:03 a.m., staff member D stated staff member F was very new to the role for wound care, and there was a large amount of education to learn. Staff member D stated was also new to infection control, as the previous DON had quit, and it was staff member D's first week working with infection prevention.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement and educate staff on an antibiotic stewardship program in order to promote the appropriate use of antibiotics. This deficient practice increased the risk for residents to develop drug-resistant organisms and/or complications. Findings include: During an interview on 9/11/25 at 8:03 a.m., staff members B, C, and D stated they did not currently have an antibiotic stewardship program implemented or provide training on the program to staff. Staff members B, C, and D stated the antibiotic stewardship program would be put in place after the next QAPI meeting, which was scheduled for 9/23/25. Review of a facility policy, titled, Antibiotic Stewardship Program, Date Reviewed/Revised 4/9/25, showed: . It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure MDS assessments were submitted timely. This deficient practice was corrected in August 2025. Findings include: Review of the MDS error dashboard, submission dates 1/1/25 - 9/8/25, showed of the 604 assessments counted, there were 190 with errors. Errors included: late MDS transmissions, late care plans for CAA signatures, late admission assessments, and resident information mismatches. Errors by the month included: -[DATE]: 16 errors.-[DATE]: 11 errors.-March 2025: 28 errors.-April 2025: 33 errors.-May 2025 no assessments submitted.-June 2025: 28 errors.-July 2025: 21 errors.-August 2025: three errors.During an observation and interview on 9/10/25 at 1:45 p.m., the facility's MDS dashboard was viewed with no late indicators shown. Staff member HH stated that once an MDS was late, it would trigger many other alerts as well. Resident mismatches were common for various reasons, including a missing middle initial or discrepancies in data from previous facilities. Staff member HH stated the late submission issues were from the previous MDS coordinator who had left in July, and maybe did not know about the 14-day submission deadline. Staff member HH stated the current MDS role was remote, and the facility was following MDS timelines.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure staff member F received the appropriate and sufficient education prior to starting a position as a wound care nurse. This deficient practice resulted in staff member F not following enhanced barrier precautions or aseptic technique while performing wound dressing changes for 2 (#s 2, and 8) of 7 sampled residents with wounds; and medication errors for 3 (#s 12, 27, and 32) of 36 medications observed. Findings include:During an interview on 9/10/25 at 8:14 a.m., staff member F explained that their position was new, and staff member F had no prior experience in wound care. Staff member F stated they did not have any wound care certifications as this was a new process (type of position). Staff member F stated they worked as a floor nurse on Mondays and Tuesdays but would work as the wound nurse on Wednesdays. Staff member F stated they often had to work overtime and take work home to finish the work for the wound care position. Staff member F stated for the new position the Weekly Wound Evaluations were completed, wound measurements, with and without using the Ipad measuring tool, identified the types of wounds, staged (determined severity) wounds, identified the characteristics of a wound, and determined the treatments for wounds. During an observation and interview on 9/10/25 at 10:13 a.m., staff member F stated that it was sometimes difficult to classify the severity of a wound due to being so new to the position. Staff member F pulled out three cards with photos on them and asked the surveyor's advice when staging and classifying (determining severity and type) of the wounds during all of the observations (on 9/10/25 at 9:24 a.m., 9/10/25 at 9:51 a.m., and 9/10/25 at 10:13 a.m.). 1. During the wound care observations (on 9/10/25 at 9:24 a.m., and 9/10/25 at 10:13 a.m.), staff member F failed to properly follow aseptic technique while performing the wound care dressings for residents #2, and #8. During the wound dressing observation for resident #2, no gown or gloves were donned prior to entering the room to follow enhanced barrier precautions; the wound care cart had been taken into the resident's room and was not cleaned after exiting the room; and multiple surfaces were touched with soiled gloves after a dirty wound dressing had been taken off of resident #2. During the wound dressing observation with resident #8, staff member F took of a dirty dressing from resident #8's right ear then touched the overhead light, the wound care Ipad, the Healx stickers, and items located within the wound care cart. Please see F880 - Infection Control, for further details related to these failures. During an interview on 9/11/25 at 3:23 p.m., staff member C stated staff member F's knowledge of wounds was a competency issue. Review of staff member F's competencies, which was requested on 9/11/25 at 4:30 p.m., showed the facility provided staff member F's generalized nursing competencies that covered Weekly Head To Toe wound competencies, but failed to show the education provided to staff member F regarding the facility wound care nurse position, specifically and the various duties requires which were relayed by staff member F during the interview on 9/10/25 at 8:14 a.m. 2. During an observation and interview on 9/9/25 at 4:04 p.m., staff member G prepared and administered medications for resident #32. The following occurred: Staff member G poured 120 mL of High Cal Med Pass into a cup. The order was for 60 mL of High Cal Med Pass. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff member G prepared Voltaren Gel by squeezing approximately two drams (1 dram = 1.77 grams) into a medicine cup. Staff member G stated she did not have a way to measure grams of the gel, so she used the drams measurement on the medicine cups. 3. During an observation on 9/9/25 at 4:20 p.m., staff member G prepared and administered medications for resident #12. Staff member G poured 120 mL of High Cal Med Pass into a cup. The order was for 60 mL of High Cal Med Pass. During an interview on 9/10/25 at 10:07 a.m., staff member G stated she found the measuring tool for the Voltaren gel in the box and asked her nurse about how to measure out the High Cal Med Pass and learned she should measure out two 30 mL medicine cups to equal the 60 mL order. Staff member G stated she was now aware she was giving double the amount listed in the orders for Voltaren gel and High Cal Med Pass for several residents. Staff member G stated she was now aware drams did not equal grams. 4. During an observation and interview on 9/10/25 at 8:05 a.m., staff member L prepared and administered medications for resident #27. Staff member L stated resident #27 prefers her Phospha 250 Neutral cut in half. Staff member L cut the pill in half and administered the medication to resident #27. Review of resident #27's physician Order Summary List, dated 9/10/25, reflected an order showing, May crush meds or open capsules as needed unless contraindicated. Review of Drugs.com Phospha 250 Neutral patient information (Phospha 250 Neutral Uses, Side Effects & Warnings), How should I take Phospha 250 Neutral? dated 2025, reflected: - The tablet form may need to be dissolved in water or swallowed whole. During an interview on 9/10/25 at 3:00 p.m., staff member D stated the nurse should have requested the liquid form of the Phospha or dissolved the pill, if the resident could not take the pill whole.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, the facility failed to ensure medication error rates remained below five percent, administering medications with the correct dose for 2 (#s 12 and 32); and the correct route for 1 (#27) of 36 sampled medications. The medication error rate was 11 percent. Findings include:1. During an observation and interview on 9/9/25 at 4:04 p.m., staff member G prepared and administered medications for resident #32. The following occurred: Staff member G poured 120 mL of High Cal Med Pass into a cup. The order was for 60 mL of High Cal Med Pass.Staff member G prepared Voltaren Gel by squeezing approximately two drams (1 dram = 1.77 grams) into a medicine cup. Staff member G stated she did not have a way to measure grams of the gel, so she used the drams measurement on the medicine cups. 2. During an observation on 9/9/25 at 4:20 p.m., staff member G prepared and administered medications for resident #12. Staff member G poured 120 mL of High Cal Med Pass into a cup. The order was for 60 mL of High Cal Med Pass.During an interview on 9/10/25 at 10:07 a.m., staff member G stated she found the measuring tool for the Voltaren gel in the box and asked her nurse about how to measure out the High Cal Med Pass and learned she should measure out two 30 mL medicine cups to equal the 60 mL order. Staff member G stated she was now aware she was giving double the amount listed in the orders for Voltaren gel and High Cal Med Pass for several residents. Staff member G stated she was now aware drams did not equal grams.3. During an observation and interview on 9/10/25 at 8:05 a.m., staff member L prepared and administered medications for resident #27. Staff member L stated resident #27 prefers her Phospha 250 Neutral cut in half. Staff member L cut the pill in half and administered the medication to resident #27. Review of resident #27's physician Order Summary List, dated 9/10/25, reflected an order showing, May crush meds or open capsules as needed unless contraindicated.Review of Drugs.com Phospha 250 Neutral patient information (Phospha 250 Neutral Uses, Side Effects & Warnings), How should I take Phospha 250 Neutral? dated 2025, reflected:- The tablet form may need to be dissolved in water or swallowed whole.During an interview on 9/10/25 at 3:00 p.m., staff member D stated the nurse should have requested the liquid form of the Phospha or dissolved the pill, if the resident could not take the pill whole. Review of the facility's policy, Medication Administration, dated 5/7/25, reflected:- 10. Ensure that the six rights of medication administration are followed .17. Administer medication as ordered in accordance with manufacturer specifications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews and record review, the facility failed to ensure medications stored for use were not expired. The failures could affect any resident using medications or supplies from the storage area. Findings include:During an observation and interview on 9/9/25 at 2:52 p.m., with staff member B, the following items were found in the medication storage room:Hydro gel expired 3/2025 x 2Vancomycin Injection fluid bags with the following expiration dates: 12/2024, 11/2024, 1/2025, 12/2024, 6/2025, 2/2025, 11/2024, 2/2025, 11/2024, and 11/2024A box of Ipratropium Bromide expired 5/2025Covid 19 test kits expired 1/18/24 x 3Lovenox expired 8/2025 x 9Timolol Opthalmic solution expired 1/2025 x 3Bisacodyl suppository expired 1/2025 x 2 boxesLatanoprost Opthalmic solution expired 12/2024 and had no patient name Wound vac supplies stored on the floor x 4 boxesDuring the medication room observations, staff member B stated she was not sure why the medications were missed during the weekly checks or why alcohol was not secured in a locked cupboard. During an interview on 9/9/25 at 3:00 p.m., staff member M stated she reviewed the medication rooms for expired medications weekly. Review of the facility's policy, Medication Storage, dated 6/25/25, reflected:- . 9. Expiration dates: Medication rooms and carts will be inspected periodically for expired medications and nurses will observe expiration dates prior to administration. Any medication found to be expired will not be administered and will be destroyed in accordance with our Destruction of unused drugs policy.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility failed to ensure resident catheter bags were covered in public areas for 1 (#25) of 2 sampled residents with catheters. Findings include:During an observation on 9/8/25 at 2:53 p.m., resident #25 was in the dining room socializing. His catheter bag was under his wheelchair. Urine was visible in the catheter bag, and there was no dignity cover.During an observation on 9/9/25 at 8:00 a.m., resident #25 was in the dining room eating breakfast. His catheter bag was under his wheelchair. Urine was visible in the catheter bag, and there was no dignity cover.During an observation on 9/10/25 at 12:20 p.m., resident #25 was in the main lobby area socializing. His catheter bag was under his wheelchair. Urine was visible in the catheter bag, and there was no dignity cover.During an interview on 9/11/25 at 3:00 p.m., staff member C stated resident #25 was care planned to not have a dignity bag cover because he would refuse.Review of resident #25's care plan, with an initiation date of 3/5/24, failed to show the refusal of a dignity bag cover under the focus area of the suprapubic catheter.Review of the facility policy, Catheter Care, dated 5/2/25, showed, Policy Explanation: . 2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use .

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Cooney Healthcare and Rehabilitation	2555 E Broadway Helena, MT 59601

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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 interview and record review, the facility exceeded the required two hour window for reporting alleged sexual abuse to the State Survey Agency for 1 (#59) of 26 sampled residents. This deficient practice increased the risk for all residents to be unprotected from the alleged sexual abuse perpetrator. Findings include: During an interview on 9/8/25 at 12:56 p.m., NF3 stated she reported an incident which appeared sexual in nature to staff member D, and the incident made her feel uncomfortable. NF3 reported it to staff member D on 9/3/25 at approximately 10:30 a.m. NF3 stated she had expressed to staff member D when she walked into resident #59's room, at approximately 10:00 a.m., she saw what appeared to be romantic relations between resident #59 and a man she thought could be her husband. NF3 stated when she saw the incident, she immediately went into the hallway and waited for approximately 30 minutes. NF3 stated, I left to give them privacy, then began to worry resident #59 was being taken advantage of, and reported the incident to staff member D. NF3 stated when she went into resident #59's room initially, she had observed a man standing up from his wheelchair, even though she could see he was a double amputee, he looked like he was vigorously turning butter, with his hips and making noises. NF3 stated resident #59's hand was near the man's groin, resident #59 was lying flat in her bed, and when resident #59 saw her (NF3), resident #59 looked shocked. NF3 stated after reporting the incident to staff member D, she left the facility and returned two hours later to complete her visit, and that was when she found out the man she had observed was resident #59's son. NF3 stated she and staff member D tried to rationalize other possibilities of what he could have been doing, then stated, But we couldn't.During an interview on 9/10/25 at 9:21 a.m., staff member A stated his policy for reporting incidents of this nature to the State Survey Agency was within two hours. Staff member A stated the Bounds (reporting system) time stamp was 10:45 a.m. on 9/4/25 for the reporting of the incident to the State Survey Agency. Staff member A stated the following reasons for not reporting the incident within two hours like he typically would were:1) There were conflicting stories,2) The family had requested the facility not to,3) He didn't know resident #59's son was a registered sex offender, 4) Resident #59 was pleasant, in no distress, and did not have any signs of negative interactions with her son,5) The allegation was vague, stating I think NF3 heard a weird sound and he was moving funny, was vague, and6) Resident #59's daughter had already asked resident #59's son to leave the facility. Staff member A stated, Once we felt it was potential sex abuse we reported it in within 2 hours.Review of a facility policy, titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, Revised April 2021, showed: . 9. Investigate and report any allegations within timeframes required by federal requirements. Review of the Facility Reported Incident #2608463, showed the State Survey Agency received the report of the incident on 9/4/25 at 12:00 p.m. This was 25 hours after the incident occurred.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to put effective measures in place to ensure further potential abuse did not occur while an investigation was in process for 1 (#59) of 26 sampled residents. This deficient practice allowed the alleged perpetrator to have continued access to the alleged victim and/or other vulnerable residents. Findings include:Review of the Facility Reported Incident #2608463, showed the State Survey Agency received the report of potential sexual abuse for resident #59 at 12:00 p.m. on 9/4/25. Resident #59 has a BIMS of 9; moderate cognitive impairment. During an interview on 9/8/25 at 1:39 p.m., staff member A stated it was harder at night to prevent resident #59's son from coming in, but it was easier during the day because the receptionist was always there. Staff member A stated even though they had never had a problem before, they were potentially going to start locking all doors to the facility at night.During an observation and interview on 9/8/2025 at 8:04 p.m., the facility's front doors were unlocked. Staff member H stated the facility's front doors were never locked or expected to be locked until tonight. Staff member H stated tonight they were unlocked because staff members had called administration and asked for the doors to stay open until 9:30 p.m. as there was a family member staying until that time.During an interview on 9/9/25 at 10:52 a.m., staff member P stated it was the policy of the facility to have all visitors sign in. Staff member P stated she tried to make everyone sign in on the visitor log, but it was hard to enforce because she was also the Office Assistant and not at the desk all the time while she was taking care of other duties. Staff member P stated she was working on 9/3/25, but did not see resident #59's son enter the facility, nor her daughter, and stated, I was doing other tasks when he (resident #59's son) came in. Staff member P stated she could not control every visitor, and stated, Sometimes I have to go to the bathroom; I'm responsible for more than just sitting here at the desk.During an interview on 9/9/25 at 11:02 a.m., staff member O stated she was the supervisor for staff member P, and it was her expectation that staff member P have all visitors sign in on the visitor log upon entering the facility. Staff member O stated staff member P did her best to have all visitors sign in, and stated, I guess she (staff member P) could ask for coverage if she (staff member P) had to step away from her desk. Staff member O stated she could not make decisions for potential alternative solutions to make sure everyone signed in on the visitor log when they entered the facility. During an interview on 9/9/25 at 11:10 a.m., staff members A and C stated everyone should sign in on the visitor log when they enter the facility, and it was the duty of the receptionist to make sure this happened. Staff member C stated, Other than shutting down the building, how can we continue a home-like environment? During an interview on 9/9/25 at 2:36 p.m., staff members E and N stated they were discussing in QAPI meetings how to make sure there would always be coverage at the front desk, even when staff member P takes a break. Staff members E and N stated they were also discussing the possibility of having a receptionist in the evening until 10:00 p.m., because the staffing was lower then, and it was hard to monitor the door for the CNAs and RNs who were taking care of residents. During an observation on 9/10/25 at 8:00 p.m., the front door to the facility was locked. The inside rehabilitation door was propped wide open, as well as the outside rehabilitation door was unlocked. There was no alarm when this surveyor exited and re-entered the facility through the unlocked rehabilitation door from the inside, going out, and vice versa. During an interview on 9/10/25 at 8:42 p.m., staff member C stated the front door to the facility was now locked to protect resident #59. Staff members A and C stated they were unaware the rehabilitation doors were propped open and unlocked, allowing access for anyone to enter the facility unannounced.Review of a facility policy, titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, Revised April 2021, showed: . 10. Protect residents from any further harm during investigations.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to notify the resident or the resident's representative, in writing, of the facility's bed hold policy when transferring a resident to the hospital; and failed to provide all pertinent information to the receiving hospital for 1 (#5) of 26 sampled residents. Findings include:During an interview on 9/9/25 at 2:00 p.m., staff member C stated the facility did not provide a notice of transfer or bed hold to resident #5 or resident #5's representative; and was not able to provide any documentation showing the receiving hospital was given a report of all pertinent information for resident #5. Staff member C stated they should have provided the information as per facility policy and did not.Review of a facility policy, titled, Transfer and Discharge (including AMA), Date Reviewed/Revised 6/10/25, showed: . 3. The facility's transfer/discharge notice will be provided to the resident and resident's representative. 8. For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: a. Contact information. b. Resident representative information. c. Advance directive information. d. All other information necessary to meet the resident's need. Diagnoses and allergies. Medications. Most recent labs.Treatments and devices. Transmission based precautions. Special risks.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure resident care plans were updated with relevant care information for 1 (#4) of 26 sampled residents. Findings include:During an observation on 9/8/25 at 4:18 p.m., resident #4 was lying in bed and pointed to a small heart monitor on his chest. Resident #4 stated he had been to the hospital because of his heart rate and there was some discussion about needing a pacemaker.Review of resident #4's hospital records, dated 7/31/25 - 8/3/25, showed the resident had experienced symptomatic bradycardia [heart rate into the 40s] while at the facility, which led to his hospitalization and ICU stay.Review of resident #4's care plan, with a most recent review date 5/28/25, failed to show any information about his bradycardia or heart monitor care.During an interview on 9/11/25 at 9:22 a.m., staff member Z stated resident #4's cardiac monitor had been blinking, so she needed to change the batteries. Staff member Z stated another nurse had shown her how to change the batteries and document any symptoms and the heart monitor settings. Staff member Z stated this information was not listed on the resident's medication or treatment records.During an interview on 9/11/25 at 12:08 p.m., staff member C stated the previous Director of Nursing did not do a progress note or care plan update related to resident #4's cardiac status and heart monitor, but she would get the orders and care plan updated. Review of resident #4's medical record after this conversation showed updated orders and care plan information.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interviews and record review, the facility failed to ensure that a resident who was incontinent of bowel received appropriate services to restore as much normal bowel function as possible for 1 (#11) of 26 sampled residents. This deficient practice resulted in resident #11 feeling humiliated and frustrated. Findings include:During an interview on 9/8/25 at 2:53 p.m., resident #11 stated he had several incontinence incidents since his admission because staff do not arrive timely enough to assist him to the toilet. Resident #11 stated CNAs would come in during the night, turn off the call light, and state they would return to help him, but would not return. Resident #11 stated he had bowel movements in his bed as a result. Resident #11 stated it often took move than 30 minutes to get assistance when he needed to use the toilet. Resident #11 stated he was normally continent of both bowel and bladder and found the incontinence episodes to be . humiliating and frustrating.Review of resident #11's Care Plan, dated 8/13/25, reflected resident #11 required moderate to substantial assistance with toileting.During an interview on 9/9/25 at 10:25 a.m., staff member F stated she had heard from resident #11 and his wife that resident #11 had a few bowel movements in his bed on night shifts. Staff member F stated the day shift did not have any trouble meeting his call light needs, and he had not had bowel movements in his bed during her day shifts. Staff member F stated resident #11 was continent of bowel and bladder so long as he had assistance to the toilet.During an interview on 9/10/25 at 8:00 p.m., staff member K stated, Staffing is terrible here at night. We need more help to answer all the call lights. We have several dementia patients wandering all night, multiple two-person Hoyer patients, and only three CNAs.During an interview on 9/10/25 at 8:05 p.m., staff member BB, stated she did not feel the staffing was safe, especially when the 6-10 p.m. float nurse left early, and then she stated, Like tonight, she left at 7:15 p.m. (float nurse), and it happens a lot. Staff member BB stated she did not like to be put in those kinds of situations because it was not safe for residents. Staff member BB stated management rarely comes in to help, then stated, They know we are short tonight, and no help. Staff member BB stated she answered call lights with in 60 seconds, even if she must go to a hall she was not covering, while some staff will ignore lights, then stated, Some staff ignore lights even if they are standing right next to a room that's alarming. Staff member BB stated, Oh there is definitely not enough staff for repositioning, most of the time it never gets done, so yeah staffing is my main concern working at this facility. Review of the facility's policy, Helping a Resident with Toileting Needs, dated 5/15/25, reflected:- It is the practice of this facility to assist residents with toileting needs in order to maintain the resident's dignity as well as proper hygiene.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure residents had fluids readily available for 1 (#55) of 26 sampled residents. Findings include:During an observation and interview on 9/8/25 at 11:26 a.m., resident #55 stated, They never let me get out of bed, I guess I'm just gonna lie around all day. Resident #55 was propped up in bed, with an empty table in front of him. There was no water pitcher or glass for the resident on the table in front of him. An old coffee mug on the side table out of reach had dried residue at the bottom.During an observation on 9/9/25 at 12:12 p.m., resident #55 was asleep in bed with his bedside table across the room. There were no beverages or beverage containers on his side of the room.During an observation on 9/10/25 at 9:11 a.m., resident #55 was lying awake in bed. There were no fluids on either of his tables.During an observation and interview on 9/11/25 at 9:20 a.m., resident #55 was lying in bed with a glass of water and a straw by his bedside. Staff member T stated resident #55 was capable of drinking from a glass on his own.Review of resident #55's care plan, review date 6/18/25, showed under focus: [Resident #55] has the potential for alteration in hydration related to: decline, dysphagia, impaired cognition, impaired vision, encephalopathy, med side effects. Interventions included encouraging food and fluid intake. [Resident #55] has an ADL self-care deficit . Interventions: Eating assistance 1 person extensive assistance.Review of resident #55's eating and drinking task documentation, dated 8/13/25 - 9/10/25, showed out of 41 documented observations resident #55 was marked:-independent four times,-setup or clean up assist 31 times,-supervision/touching assist five times, and-substantial assistance once.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure psychotropic medications were used with appropriate diagnoses and behavioral monitoring for 1 (#72) of 26 sampled residents. Findings include:Review of resident #72's medication administration record, September 2025, showed the resident received 25mg of Seroquel [an antipsychotic] for a diagnosis of dementia.Review of resident #72's medical record, dated 9/5/25 to current, did not show any behavioral notes or other indications for Seroquel.During an interview on 9/8/25 at 2:59 p.m., NF2 stated resident #72 had been started on Seroquel while in the hospital due to some delirium at night.During an interview on 9/10/25 at 8:20 p.m., staff member BB stated they had not heard of resident #72 having behaviors at night and would have to check her progress notes.During an interview on 9/11/25 at 3:48 p.m., NF8 stated when reviewing medications for appropriateness they would look at diagnoses, review progress notes for behaviors, and ask for clarification on the dementia aspect. NF8 stated resident #72's current dementia diagnosis was listed as dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to assist a resident in making appointments and transportation to and from the dental services for dentures, for 1 (#2) of 26 sampled residents. This deficient practice prevented a resident from eating her preferred diet. Findings include:During an observation and interview on 9/9/25 at 7:54 a.m., resident #2 stated she had been waiting for a denture appointment for a long time. Resident #2 stated she was missing her dentures and could not eat the foods she preferred. Resident #2 stated she was told the facility was scheduling her denture appointment when she was admitted on [DATE] but had not heard anything since. During an interview on 9/9/25 at 10:18 a.m., staff member E stated she told transport about the denture appointment two weeks ago. Staff member E stated the dentures had already been paid for and she only needed to go into the denture clinic for fittings. During the interview, staff member E called the transportation department and was told the appointment fell through the cracks because the denture clinic was closed for a week, and no one had called to schedule the appointment upon the clinic's reopening. Review of the facility's policy, Dental Services, dated 6/10/25, reflected: - . 4. The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location.