STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275106	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Intermountain Health Holy Rosary Hospital	2600 Wilson St Miles City, MT 59301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 14005 Based on observation, interview, and record review, the facility failed to maintain a safe environment, free from elopements, for 4 (#s 16, 17, 18, and 24), and the facility failed to provide an environment free from accidents and hazards for 1 (#42) of 18 sampled and supplemental residents. This deficient practice had the potential to adversely affect the well-being and safety of all residents in the facility. Findings include: 1. Review of the Facility Reported Incident, dated 8/31/24, showed resident #24 left the Residential Living side of the facility, and the resident eloped into the hospital. The facility identified the alarm between the two areas had not been activated. During an interview on 2/25/25 at 11:17 a.m., staff member B said resident #24 eloped because the alarm on the dining room doors, which led to the hospital, were not activated. Staff member B said staff were educated to ensure the alarm was set to alarm if the door to the hospital was opened. But, no system was put in place to monitor the status of the alarm. Staff member B said if the alarm was not set properly, it increased the risk for residents to elope to the hospital. During an interview on 2/26/25 at 12:35 p.m., staff member B said the facility did not have an elopement assessment for the residents in the Residential Living area and none of the residents had been assessed for elopement risk. Staff member B said the facility was working on developing an elopement assessment for the Residential Living area. Staff member B said resident #s 16, 18, and 24 were at risk for eloping. During an interview and observation on 2/26/25 at 5:24 p.m., staff member I said she did not know how to identify the residents at-risk for elopement. She said, I would think the residents at risk for eloping would be the ones who hang around the door. Staff member I said the only resident she knew of who was an elopement risk was resident #24. Resident #24 was observed near the front exit door during this interview. During an interview on 2/26/25 at 5:28 p.m., staff member J said there were two residents at risk for elopement, resident #s 17 and 24. During an interview on 2/26/25 at 5:40 p.m., staff member K identified two residents who were at risk for wandering and eloping. She identified residents #s 17 and 24. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/25 at 7:47 a.m., staff members A and B said the elopement book was not current or updated. Staff member B said it would not surprise her if there were seven residents identified in the elopement binder. Staff member A said the staff should know which residents were at risk for eloping by looking at the care plan or the C.N.A. assignment sheet. 2. During an observation on 2/24/25 at 4:34 p.m., there was an unsecured work bench in the activity room, which was accessible to the residents. On the bench, and within easy reach of residents, were the following items: - Double-edged wood working hand saw, - T-handle screwdriver, - Numerous bottles of paint; and, The work bench contained two easy sliding drawers which contained: - Large tin snips, - [NAME] grips, - Utility knife with a sharp blade, - Wire cutters, - Pipe wrench, - Drill and drill bits - Ball peen hammer, - Hacksaw During an observation and interview on 2/24/25 at 4:30 p.m., resident #42 was sitting in her wheelchair near the work bench in the activity room. Resident #42 stated, That looks like a lethal weapon. Resident #42 was pointing to the double-edged wood saw. During observations on 2/25/25 at 8:30 a.m., and 2/26/25 at 11:50 a.m., the activity room contained a work bench which was not locked. The tools were accessible with some tools on top of the bench and the rest of the tools in the drawers. The tools and paints were not secured, and the drawers were not locked. The activity room was also not locked. During an interview on 2/25/25 at 11:27 a.m., staff member E said when maintenance needs to do repairs in the Residential Living area, the staff bring a tool chest to the area, or a handheld pouch of tools, depending on the size of the job. Staff member E said none of the maintenance tools are left where residents could access them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/25 at 3:19 p.m., staff member G said the activity doors are always open, and all the residents can go in and out any time they want. Staff member G said she was not sure how the safety of the tools was maintained. Staff member G said all the tools could be accessed by any resident right now because the tools were just sitting out on the bench or in the drawers. During an interview and observation on 2/25/25 at 3:31 p.m., staff member A was in the activity room looking at the resident work bench. Staff member A said the tools, which belonged to a resident, were put away and the drawers under the bench were closed when the tools were not in use. During this observation, the screw drivers, the T-handled screwdriver, and the metal ruler were readily accessible. The drawers were closed, however the drawers opened easily, and the listed tools were all accessible to residents.