| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275106 | A. Building<br>B. Wing | 04/23/2026 |

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

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview and record review, the facility failed to report investigation findings to the State Survey Agency (SSA) within the required timeframe of 5 working days for 4 (#s 21, 29, 44, and 62) of 25 sampled and supplemental residents. Findings include:A review of Facility Reported Events showed:<br><br>1. Review of the facility's reported incident, dated 1/24/26, showed, Resident (#44) came out of her room and went over to another resident (#62) and kicked her feet.<br><br>Review of the facility's investigative findings for the incident reported on 1/24/26, between resident #s 44 and 62, was submitted to the SSA on 2/4/26, 11-days after the facility reported the incident.<br><br>2. Review of the facility's reported incident, dated 3/20/26, showed, One resident (#29) kicked another resident (#44) in the legs while both were in their wheelchairs. No injuries noted or reported from the resident who was kicked. Immediate interventions were to separate the residents.<br><br>Review of the facility's investigative findings for the incident reported on 3/20/26 did not show that the facility submitted investigative findings to the SSA.<br><br>3. Review of the State Survey Agency reporting site showed the facility made initial reports of elopement for resident #21 on 7/18/25 and 2/1/26. The facility failed to submit the final investigation within the required five working days. There was no final report for the elopement on 7/18/25 and 2/1/26.<br><br>During an interview on 4/21/26 at 4:01 p.m., staff member A stated that staff member B was responsible for reporting and submitting the investigative findings to the SSA for allegations of abuse. Staff member A stated staff member B was out of the facility the week of the survey. Staff member A stated it was the expectation to report the findings of any allegation of abuse to the SSA within five working days of the initial allegation. Staff member A stated they were not able to provide investigative findings for the incident that occurred on 3/20/26, between residents #s 29 and 44.<br><br>Review of the facility's policy and procedure titled, Abuse Investigation and Reporting Procedure - Long Term Care, with a review date of 7/15/25, showed:<br><br>-Procedure: What is to be reported: .The results of all investigations of alleged violations. When: Results of all investigations of alleged violations - within 5 working days of the incident. |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse, failed to prevent further potential abuse, and failed to report the results of the investigation to the State Survey Agency (SSA) to verify corrective actions were taken for allegations of resident-to-resident abuse for 2 (#s 29 and 44); and the facility failed to document a thorough investigation of multiple elopements and identify the root-cause of the elopements for 3 (#s 21, 61, and 62) of 25 sampled and supplemental residents. These failures had the potential to cause the facility to miss key parts of the investigation and prevent further elopements or injuries to the residents and increased the risk for more than minimal harm by creating an environment that perpetuates a disrespectful situation between residents. Findings include:1. Resident-to-Resident<br><br>Review of the facility's reported incident, dated 3/20/26, showed, One resident (#29) kicked another resident (#44) in the legs while both were in their wheelchairs. No injuries noted or reported from the resident who was kicked. Immediate interventions were to separate the residents.<br><br>A. Failure to Investigate:<br><br>Review of resident #44's Nursing Note, dated 3/20/26, showed, Resident (#44) was kicked multiple times in the lower legs by another resident (#29) while both were in their wheelchairs at the nurses station. No injuries noted.<br><br>A review of the facility's abuse investigations completed between March 2026 and April 2026, showed the facility failed to complete an investigation related to the reported allegations of resident-to-resident abuse between resident #s 29 and 44, reported on 3/20/26.<br><br>B. Failure to Protect:<br><br>Review of resident #29's Nursing Note Addendum, dated 3/22/26, showed at 7:00 p.m. Observed another resident continually attempting to follow, communicate, agitate and argue with [Resident #29]. Staff separated twice. Information communicated to other staff to monitor interactions between her [and] other resident. [sic]<br><br>Review of resident #44's Nursing Note Addendum, dated 3/22/26, showed at 7:00 p.m. Observed [Resident #44] continually attempting to follow, communicate, agitate and argue with another resident (resident #29). Staff separated twice. Information communicated to other staff to monitor interactions between her [and] other resident. [sic]<br><br>Review of residents #s 29 and 44's Nursing notes on 3/22/26, showed the facility failed to prevent potential further abuse between the two residents.<br><br>C. Failure to Report:<br><br>A review of the facility reported investigative findings for the incident reported on 3/20/26, between residents #s 29 and 44, did not show that investigative findings were reported to the SSA (See F609).<br><br>During an interview on 4/21/26 at 4:01 p.m., staff member A stated staff member B was responsible for investigating and reporting allegations of abuse. Staff member A stated staff member B took over the reporting and investigating of allegations of abuse after the staff member who was coordinating<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | those investigations left in September of 2025. Staff member A stated staff member B was out of the facility the week of the survey and was not available for an interview. Staff member A stated they were not able to provide the documentation for what was completed during the investigation of the allegation between resident #s 29 and 44, or the investigative findings. Staff member A stated they were not able to verify whether the investigation was completed or that it was reported to the state agency. Staff member A stated it was the expectation to thoroughly investigate allegations of potential abuse, protect the residents, prevent further potential of abuse during the investigation, and report the findings from the investigation to the SSA.<br><br>2. Elopements:<br><br>A. Review of resident #21's elopement investigation dated 7/14/25, showed information about resident #21 exiting the facility. There were no signatures or names of where this information was obtained. An email was included as part of the investigation, but the sender of the email was not identified by title or how the person was involved in the investigation.<br><br>Review of the state abuse reporting website dated 2/1/26 at 10:00 a.m., showed resident #21 was brought back from Med-Surg by Med-Surg nurse. Resident eloped through back doors either following volunteer or staff taking other resident's to Mass. No alarms were triggered when she got out of RLU. PCP, Administrator, DON, MDS and social worker notified of incident. There was insufficient investigation completed to identify the root-cause of the elopement, and the facility neglected to address the reason or interventions put into place to prevent the elopement.<br><br>B. Review of the reportable incident submitted to the SSA on 7/24/25 showed resident #61 eloped through the doors leading into the hospital. Review of resident #61's electronic health record showed there were no nurses' notes that were written on 7/24/26 describing the elopement. Review of the nurse's note dated 7/25/26, showed resident #61 attempted to elope twice on 7/24/25, reflecting a lack of oversight.<br><br>The facility investigation, dated 7/30/25, for resident #61's elopement on 7/24/25, showed an interview involving two staff members. The interview showed that resident #61 left shortly after arrival. He was lost and confused - didn't seem to be exit seeking - just going back through doors he came in - [Nurse Name] found him exiting - door alarms. Second time he followed other residents out patio door by Activities. Alert residents were outside. Another staff member interview stated, RN was bringing him back. She heard alarms and went to doors. She alerted [Nurse Name] for resident #61. Not exit seeking.<br><br>The facility neglected to interview certified nurse assistants or activity staff to develop a timeline of resident #61's movements at the time of the elopement. The facility neglected to identify the root cause.<br><br>Review of resident #61's Nursing Note, dated 8/12/25, showed that resident #61 eloped into the hospital on 8/12/25. The alarm sounded alerting the staff resident #61 had left through the exit to the hospital.<br><br>Review of the facility's investigation, undated, of resident #61's elopement on 8/12/25, included a staff member's handwritten note, which was undated, and it showed People came in RLU looking for someone in hospital. They left unit to go to the M/S and resident #61 followed them out the door. The door alarm was on and working. Resident #61 did come back to the unit. The facility neglected to<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | identify the root cause of the elopement. There was no timeline developed, nor were interviews completed to identify the activities or interventions that had been implemented to determine the effectiveness of elopement prevention.<br><br>C. Review of the facility's investigations for Facility Reported Incidents of resident #62's elopements showed:<br><br>- on 5/3/25, resident #62 exited the facility. The facility investigation file contained the bounds report and staff members' statements.<br><br>- on 6/29/25, resident #62 exited the facility without staff awareness. The facility investigation file contained only a summary of the incident.<br><br>- on 7/11/25, resident #62 exited the Residential Living Unit and was found wandering in the hospital. The facility investigation file contained an incomplete investigation checklist and a summary of the incident.<br><br>- on 9/9/25, resident #62 exited the facility. The facility investigation file contained a summary of the incident and an invoice for a wander guard system.<br><br>- on 9/22/25, resident #62 exited the facility and was brought back by an unknown staff member. The facility investigation file contained a summary of the incident, interventions, and a new process for the wander guard system. The file did not contain a root-cause analysis or assessments.<br><br>- on 9/26/25, resident #62 exited the facility and was brought in by another resident's family member. The facility investigation file contained the bounds report, a summary of the incident, and interviews with staff.<br><br>- on 1/4/26, resident #62 made it through the main doors and was stopped between the two doors. The facility investigation file contained a summary of the incident.<br><br>- on 1/20/26, resident #62 exited the facility by pushing the doors open and closing them. The facility investigation contained the bounds report submitted to the SSA and a summary of the incident.<br><br>Review of resident #62's electronic health record showed a discharge plan was in place, and resident #62 was discharged to a memory care facility on 2/12/26.<br><br>The facility failed to identify and document the root causes of resident #62's exit seeking and elopements, which led to a fall with injury (see F689).<br><br>During an interview on 4/21/26 at 3:46 p.m., staff member A stated NF1 used to conduct the incident investigations and has been gone since October 2025. Staff member A stated, .the expectation on conducting an investigation would be to find the root cause. Why is this happening? . Staff member A stated they would monitor the residents to ensure interventions were being implemented.<br><br>During an interview on 4/22/26 at 1:56 p.m., staff member V stated that after each elopement, the nurse would file a report to the SSA and update the resident's care plan with new interventions. After they were done with that part, it would go to management for a full investigation to be conducted.<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/23/26 at 10:01 a.m., staff member A stated that when a resident eloped, the nurse would enter an occurrence report in the EHR and submit a report to the SSA. Staff member A stated that this was how the staff tracked the elopements. Staff member A stated they monitor interventions by observing them to see if they were being implemented. Staff member A stated that they (staff) talk about the root cause, but have not kept that documentation.<br><br>Review of the facility's policy and procedure titled, Abuse Investigation and Reporting Procedure - Long Term Care, with a review date of 7/15/25, showed,<br><br>- Procedure: What is to be reported: . All alleged violations of abuse, neglect, exploitation or mistreatment.<br><br>- The results of all investigations of alleged violations.<br><br>- Take steps to prevent any further abuse, neglect, exploitation, or mistreatment while the investigation is happening. If the allegation is confirmed, take the necessary corrective actions. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide sufficient supervision and interventions to prevent an elopement for 4 (#s 21, 38, 61, and 62) of 23 sampled residents, which led to a fall with minor injury for resident #62. Findings include:1. During an interview on 4/20/26 at 2:40 p.m., staff member M said the facility got a wander guard alarm for the front door some time before Christmas 2025. Staff member M said the alarm was activated by a bracelet. Staff member M said the bracelet was placed on the resident or on the residents mobility devices. Staff member M said most elopements happened when residents exited through the front door. Staff member M said the other exit doors have (breakaway) alarms which ring if activated. Staff member M said the residents are assessed by the Minimum Date Set (MDS) nurse for risk of elopement on admission and quarterly. Staff member M said if the nurses identified a resident was at risk, the wander guard bracelet could be applied without an assessment.<br><br>During an interview on 4/21/26 at 9:57 a.m., staff member T said he was not working when any residents eloped. Staff member T said the certified nurse assistants were provided with a piece of paper which had information about each resident included on the paper. Staff member T said the staff were aware of the residents who were at high risk of eloping because the information was noted on the form the brain (mini care plans for each resident).<br><br>2. Review of resident #21's current care plan showed, resident #21 was at risk of eloping and had interventions to prevent elopement. Resident #21's care plan showed she was able to self-propel through the facility in her wheelchair and would go to the doors and attempt to open them. The facility failed to prevent resident #21 from eloping by involving her in activities and using redirection. Resident #21's care plan, dated 9/26/24, had an anti-wander device attached to her wheelchair. Resident #21 eloped while the wander guard bracelet was on her chair.<br><br>During an interview on 4/23/26 at 8:04 a.m., staff member D said the care plans have a certain number of blank spaces and new interventions were added. Staff member D said resident #21's care plan was incorrect as the facility did not have a wander guard door in 2024. The wander guard door alarm was available in late 2025. Staff member D said resident #21 was a wander risk and the staff were aware of her risk.<br><br>Review of resident #21's nursing note, dated 7/14/25 at 6:44 p.m., showed, This nurse received report from CNA that resident went through the first set of doors, was in the corridor when found by other resident and brought back into main entrance of ECU . The nurses note showed the intervention to prevent further elopements would be to increase monitoring and activities from 3:00 p.m. to 6:00 p.m. Review of the state abuse reporting website dated 2/1/26 at 10:00 a.m., showed resident #21 was brought back from Med-Surg by Med-Surg nurse. Resident eloped through back doors either following volunteer or staff taking other resident's to Mass. No alarms were triggered when she got out of RLU. PCP, Administrator, DON, MDS and social worker notified of incident.<br><br>Review of resident #21's electronic health record failed to show any nurses note or any documentation of the elopement which occurred on 2/1/26.<br><br>During an interview on 4/23/26 at 9:22 a.m., staff member F said when the activity department had three staff members, someone from activities stayed until 7:00 p.m. The three staff were available<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | until 1/2/26. Staff member F said the funding for the third employee had been cut from the budget, so the activity staff did not stay late any longer. Staff member F said there were no organized activities after 5 p.m.<br><br>3. Resident #38 's Risk of Elopement Wandering Review, dated 3/24/25 showed resident #38 was at risk for eloping or wandering.<br><br>Review of resident #38's care plan, dated 3/24/25, showed resident #38 was at risk for elopement due to dementia and she had a (BIMS) brief interview for mental status score of three. A BIMS score of zero to seven indicates severe mental impairment. Resident #38's care plan interventions for elopement showed resident #38 will receive re-direction if she attempts to exit the unit, diversional activities will be provided, and staff will assure the door alarms were activated on all exit doors. A sign was posted at the main entrance to remind visitors not to allow residents out behind them.<br><br>Review of resident #38's nurses notes dated, 7/24/25 at 3:35 p.m., showed, Resident got out in between the sliding front doors presumably as someone was coming in or going out and no one seen her go out. The facility did not follow the care plan which showed the resident would not leave the facility and the staff would redirect the resident if she attempted to elope.<br><br>4. Review of resident #61 nurses note, dated 7/24/25, showed resident #61 was admitted to the facility following a hospitalization. The nurses note showed resident #61 repeated questions frequently showing he had problems with his short-term memory.<br><br>Review of resident #61's nursing note, dated 7/25/26 at 1:33 p.m., showed resident #61 attempted to elope twice. One elopement was out the double door at the end of a hallway, and the other elopement was out the door to the outside of the facility. Both elopements occurred between three and five p.m The intervention to prevent further elopement was to remind resident not to leave the facility, however resident #61 had dementia with short term memory problems.<br><br>Review of resident #61's Risk of Elopement/Wandering Review, dated 7/25/25 at 8:25 a.m., showed resident #61 was at risk for elopement. Review of resident #61's care plan for elopement interventions showed the care plan and intervention were not initiated until after resident #61 eloped from the facility twice.<br><br>Review of the SSA abuse submission portal showed resident #61 eloped on 8/12/25. A request was made 4/21/26, requesting the nurse progress notes through 8/30/25. The nurses note regarding the elopement of 8/12/25 was not provided by the end of the survey on 4/23/26.<br><br>5. Review of a Facility Reported Incident, with a date of 1/18/26, showed: Resident #62 had been exit seeking throughout the day. Resident #62 exited out of the main entrance to the facility by pushing open the sliding doors and closing them behind her. The resident was in her wheelchair. The facility used camera footage to determine how the resident eloped. Resident #62 was witnessed by an oncoming staff member, falling while trying to walk down the stairs. Resident #62 had an abrasion to the right side of her face and bruising to her right side. Resident #62 was sent to the hospital for evaluation, and the X-rays came back negative. This report showed the resident did have an anti-elopement alarm device on her wheelchair that sounds as she approaches the door. Resident #62 had been near the door, setting the alarm off throughout the day.<br><br>During an interview on 4/22/26 at 10:03 a.m., staff member W stated resident #62 was very adamant (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | about her independence and sometimes had behaviors toward staff. Staff member W stated some of the interventions in place for resident #62 were 1:1 monitoring, taking her outside, folding laundry, along with other interventions she could not remember.<br><br>During an interview on 4/22/26 at 1:56 p.m., staff member V stated, She (resident #62) was sweet but hard to manage. She was all over the place. Staff member V stated they (staff) would update the care plan after each elopement with new interventions and submit the report to the state.<br><br>During an interview on 4/23/26 at 10:01 a.m., staff member A stated they tracked elopements by staff entering occurrence reports in the EHR and the state reports they submitted to the SSA. Staff member A stated, The way we monitor interventions depends on the intervention. The device on the door is monitored by the night shift. Most interventions we would just observe to make sure they were being done, such as putting her (resident #62) in the recliner to relax. We would discuss interventions at the morning huddle meeting and our IDT meetings. The care plan would be updated anytime interventions were changed and after each incident. Staff member A stated they would discuss the root-cause of the elopements, but they did not document them.<br><br>Review of a facility document titled SBAR & Procedure for Anti-Wandering Door Alarm for Elopement Risk Residents with a date of 9/24/25, showed:<br><br>.5. Response to alarm: a. If an alarm is triggered, immediately locate all residents to ensure they are in a safe place. c. If an elopement occurs, follow the Elopement Procedure in [NAME].<br><br>The facility failed to identify the resident's need for one-on-one monitoring to prevent the resident from exiting the facility unsupervised, failed to respond to an anti-elopement door alarm, and failed to prevent the resident from experiencing a fall with injury. |