

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Intermountain Health Holy Rosary Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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 interview and record review, the facility neglected to ensure resident-specific care plan interventions were implemented requiring use of a gait belt and continuous physical support during transfers. for 1 (#1) of 3 residents sampled for falls. The failure resulted in the resident sustaining an uncontrolled fall with increased pain requiring emergency department evaluation and subsequent transition to palliative care for pain management. Findings include: Review of a Facility-Reported Incident, submitted to the State Survey Agency on 5/11/26, showed resident #1 experienced a witnessed fall on 5/3/26 while staff assisted the resident from her room to a recliner in the sitting area. Resident #1 used a four-wheeled walker and did not have a gait belt in place for safety or staff assistance. Upon arrival at the recliner, the staff member stepped in front of the resident to adjust a chair pad. Resident #1 lost her balance and fell backward, landing on her buttocks. The staff member was unable to prevent the fall because she was no longer maintaining physical support of resident #1, and no gait belt was in use at the time for safety. During an interview on 7/27/26 at 3:40 p.m., staff member A stated resident #1 had a history of spinal compression fractures with chronic pain. Staff member A stated resident #1 did not initially report pain following the fall but developed worsening pain beginning the following morning. Staff member A stated the family declined radiology testing after the fall. Staff member A stated resident #1 transitioned to palliative care on 5/8/26 for pain management. During an interview on 7/27/26 at 1: 28 p.m., staff member D stated resident #1 had been receiving restorative services, but had been having a little more trouble with pain and balance . During a telephone interview on 7/28/26 at 9:20 a.m., NF1 stated resident #1 had chronic back pain related to compression fractures and did not experience increased pain until after the fall on 5/3/26. NF1 stated she did not want to subject resident #1 to additional testing because of the resident's advanced age and chronic pain. NF1 stated the facility was unable to adequately control resident #1's pain following the fall and palliative care was initiated for comfort-focused pain management. NF1 stated the facility could have monitored resident #1 more closely during transfers and stated, When she fell, nobody was holding onto her (the resident). Review of resident #1's diagnosis list showed diagnoses including dementia, osteoporosis, vertebral compression fractures, and history of falls. Review of resident #1's care plan showed an intervention initiated on 12/15/25 for safety during transfers, and the plan was directing staff to assist resident #1 and to use a gait belt during transfers and ambulation. The intervention remained in effect on 5/3/26 and had not been discontinued or revised. The staff member assisting resident #1 when the fall occurred did not follow the care plan intervention(s) for safety. Review of resident #1's nursing progress notes showed the resident experienced previous falls on 4/23/26 and 5/1/26. During those events, staff used a gait belt and controlled resident #1's descent to the floor. The progress notes did not show increased pain following those falls, and chronic pain remained managed without changes to the resident's pain (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 - Actual harm Residents Affected - Few	management regimen. Review of resident #1's nursing progress note dated 5/4/26 at 10:20 a.m. showed, Noted [Resident #1] . in obvious pain-moaning, gasping in pain and unable to sit still. Multiple residents noting her pain and asking staff to do something for her . attempted to give her pain medication crushed in applesauce and she was unable to swallow it. [sic] Review of resident #1's post-fall note dated 5/4/26 at 11:34 a.m. showed resident #1 exhibited substantial pain with facial grimacing and moaning and was transferred to the emergency department for evaluation. Review of resident #1's emergency department record, dated 5/4/26 at 11:50 a.m., showed: . CHIEF COMPLAINT: Fall and Back Pain . History of Present Illness: Pt presents to the ED after having multiple falls over the last couple of days . Pt fell again yesterday and since then increased pain and difficult to manage the patient's pain . [sic] Review of resident #1's nursing progress notes dated 5/5/26 through 5/8/26 showed ongoing, escalating pain despite administration of as-needed pain medications, including Norco, tramadol, lidocaine patches, and ibuprofen, with limited relief. Documentation described persistent grimacing, moaning, vocal expressions of pain, and increased distress during movement and care. Review of a facility document titled Residential Living Statement Form, dated 5/3/26 at 5:00 a.m., showed staff member H's summary of resident #1's fall as follows:- I went to switch the incontinence pad off the chair. Patient was walking with front wheel walker and became unsteady. Patient couldn't catch her balance and I wasn't immediately behind her. Patient started to fall back and her bottom hit the floor before I was able to get behind her and hold her on to her upper body. [sic] - The document further showed the question: What could have been done to prevent this incident? Describe: Staff member H wrote the following: Being in closer proximity to the patient, being immediately behind her and properly using gait belt, or using other devices like wheelchairs, since patient has been in pain and unsteady lately. A request was made for a telephone interview with staff member H via voicemail on 7/27/26 at 2:30 p.m. No return call was received by the end of the survey. Review of a facility document titled, Holy Rosary Residential Living Standards of Care, undated, showed: . TRANSFERS . Gait belts are to be used for all one-to-two-person assist transfers . review the resident's care plan for ambulation/transfer assist . Review of a facility policy titled, Fall Prevention, dated 4/21/26, showed: . Have a gait belt readily available at the patient's bedside (if necessary) for use during ambulation or transfer .		

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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 failed to ensure an allegation of possible neglect involving 1 (#1) of 3 residents sampled for abuse and neglect was reported to the State Survey Agency within the required timeframe. The facility's failure delayed notification to the State Survey Agency and the agency's ability to determine whether additional oversight or investigation was warranted. Findings include: Review of a Facility Reported Incident submitted to the State Survey Agency on 5/11/26 showed resident #1 sustained a fall on 5/3/26 during an assisted transfer. The investigation showed the facility determined staff neglected to use the resident's required gait belt and walked away from the resident to adjust a chair pad, leaving the resident without continuous support. Resident #1 fell backward to the floor. The resident subsequently developed increased back pain, was transferred to the emergency department for evaluation, later transitioned to comfort-focused care, and passed away on 5/8/26. The documentation showed the neglect incident became known to the facility on 5/3/26. The incident was not electronically submitted to the State Survey Agency until 5/11/26, seven days after the neglect incident occurred. Refer to F689 Accidents and Hazards for information related to the resident's fall. During an interview on 7/27/26 at 4:22 p.m., staff member A stated she was responsible for submitting the facility-reported incidents to the State Survey Agency through the Bounds (electronic reporting) system. Staff member A stated she was aware the report had been submitted late, stating she had completed the report on time; however, she inadvertently hit the save button instead of the submit button. The error was not discovered until 5/11/26, when it was then submitted to the State Survey Agency. Review of a facility document titled, Reportable Event Procedure, dated 6/30/25, showed: Purpose: To outline the notification, response, reporting and follow up requirements for Reportable Events . 9. Report to state and/or regulatory agencies if appropriate criteria for reporting are met . initial occurrence reports are due . no later than end of the next . business day .		