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	04/23/2026

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

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the medical director or his designee attended and/or participated in the Quality Assurance (QA) program at least quarterly. This deficient practice increased the risk of negative outcomes for residents with respect to quality assessment and assurance activities. The facility reported a census of 54 residents. Findings include:During an interview on 4/20/26 at 3:13 p.m., staff member A stated staff member G was onsite at the facility once a month. She stated when staff member G was onsite at the facility, it did not always correspond with when QA was scheduled to meet. Staff member A stated staff member G was not currently attending the QA meetings quarterly either in person, or via videoconferencing or teleconference calls, and did not have an authorized designee to attend instead. She stated she did review the QA minutes with staff member G but did not have documentation of staff member G's acknowledgement of the provided QA information.Review of the QAPI Agenda and/or Attendance Roster, dated 9/9/25 through 4/24/26, failed to include staff member G as an attendee. There was no evidence staff member G had a designee to attend the QA meetings and/or that a non-required member of the QA committee had communicated the meeting content to staff member G for his acknowledgment. During an interview on 4/23/26 at 8:41 a.m., staff member G stated he currently had not been attending the QA meetings in person or via an electronic means and did not have a designated proxy to attend in his absence. Staff member G acknowledged attendance of the QA meetings was an expectation of his current role.Review of staff member G's Professional Service Agreement, signed 10/25/24, showed:- 3. Contractor's Obligations. Contractor, through Medical Director, shall provide the following services (the Medical Director Services):a. Develop, maintain, and update, as may be reasonably appropriate, clinical quality control programs and protocols that meet the legal requirements of state and federal statutes and regulations applicable to the Unit, including: (a) performance and utilization standards.

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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility failed to provide required effective communication training to all direct care staff. This deficient practice had the potential to affect the care of all residents residing in the facility. Findings include:During an interview on 4/22/26 at 1:30 p.m., staff member A stated the last all staff training which would have included effective communication was last provided on 8/29/24. She stated the next all staff training on effective communication was due 8/29/25. Staff member A stated they did establish a training program, which included effective communication, which they failed to implement by 8/29/25. Staff member A stated it was the expectation for all direct care staff to receive training on effective communication at hire, and annually thereafter.Review of the facility's all staff training for effective communication showed the last training was provided on 8/29/24.A request was submitted to the facility for a policy and procedure on staff education/training requirements for effective communication on 4/22/26 at 4:00 p.m. The facility did not provide additional documentation for the staff training requirements for communication training by the end of the survey on 4/23/26.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to provide required dementia training to include management of dementia related behaviors to all staff. This deficient practice had the potential to affect the care of residents with dementia health needs in the facility. Findings include:During an interview on 4/22/26 at 1:30 p.m., staff member A stated the last all staff dementia training occurred on 8/29/24. She stated the next annual dementia training was due 8/29/25. Staff member A stated all staff have not been provided dementia training since 8/29/25. She stated they did establish a training program for dementia which they failed to implement by 8/29/25. Staff member A stated it was the expectation for all staff to receive dementia training to include management of dementia related behaviors at hire and annually thereafter.During an interview on 4/22/26 at 1:56 p.m., staff member V stated the facility used quarterly workday assignments to assign training. Staff member V stated she did not remember doing any specific dementia training. During an interview on 4/22/26 at 3:11 p.m., staff member X stated she had dementia training about two years ago at this facility. Staff member X stated they have not done any training on dementia since then. Review of the facility's all staff training for dementia care showed the last training was provided on 8/29/24. A request was submitted to the facility for a policy and procedure on staff education/training requirements for dementia care and on 4/22/26 at 4:00 p.m. The facility did not provide additional documentation for the staff training requirements for dementia training by the end of the survey on 4/23/26.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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: 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. 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. 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. 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. 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. 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. 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: -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.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 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 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. A. Failure to Investigate: 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. 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. B. Failure to Protect: 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] 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] 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. C. Failure to Report: 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). 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm 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. 2. Elopements: 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. 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. 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. 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. 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. 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. 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm 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. C. Review of the facility's investigations for Facility Reported Incidents of resident #62's elopements showed: - on 5/3/25, resident #62 exited the facility. The facility investigation file contained the bounds report and staff members' statements. - on 6/29/25, resident #62 exited the facility without staff awareness. The facility investigation file contained only a summary of the incident. - 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. - 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. - 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. - 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. - 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. - 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. 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. 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). 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm 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. 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, - Procedure: What is to be reported: . All alleged violations of abuse, neglect, exploitation or mistreatment. - The results of all investigations of alleged violations. - 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 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. **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. 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). 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. 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. 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. 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. 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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. 3. Resident #38 's Risk of Elopement Wandering Review, dated 3/24/25 showed resident #38 was at risk for eloping or wandering. 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. 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. 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. 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. 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. 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. 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. 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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	275106	A. Building B. Wing	04/23/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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. 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. 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. 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: .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]. 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.

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	04/23/2026

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

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interviews, and record review, the facility failed to ensure a comprehensive grievance process was operationalized and followed effectively by staff for the resolution of a grievance related to the provision of personal resident care, for 1 (#5) of 23 sampled residents. Findings include:During an interview and observation on 4/22/26 at 11:20 a.m., resident #5 and NF3 said that resident #5 had some concerns with the care he received from the certified nurse assistants. NF3 provided a copy of the grievance dated 3/12/26. NF3 said the resident #5 and his family asked him not to get milk-based supplements. NF3 said resident #5 had a hiatal hernia, which was aggravated by milk. NF3 said the milk-based supplement made resident #5 have more phlegm and mucous, which caused resident #5 to be more congested and increased his cough. Resident #5's lunch tray was observed. The tray included a large glass of milk-based supplement. NF3 said the grievances had not been resolved to the satisfaction of resident #5 or the family.During an interview on 4/22/26 at 4:05 p.m., staff member A said she was aware of a letter of concern that resident #5's family wrote and gave to the facility. Staff member A said the letter was given to staff member B to address the grievance. Staff member A said she did talk to resident #5's daughter about the letter and the concerns. Staff member A said she did not put a copy of the letter into the grievance file, which was given to the surveyors. Staff member A said staff member B spent time with the family working through the concerns, but no documentation could be provided to show the outcome of the concerns.During an interview on 4/23/26 at 9:24 a.m., staff member A said resident #5's grievance was in staff member B's file, and neither the grievance form nor the follow-up could be accessed.Review of a facility document titled Complaint Grievance Policy-Long Term Care, with a review date of 9/16/25, showed: .A resident has the right to voice a complaint or grievance and prompt efforts by the facility to resolve grievances or complaints that the resident may have without worry of reprisal.Efforts to resolve include facility acknowledgement of complaint/grievance and actively working toward the resolution of the complaint/grievance (initial response may be immediate as required or generally within 7 working days).7. After receiving a complaint/grievance, [Facility Name] will actively seek a resolution and keep the patient/resident appropriately apprised of progress toward resolution.7.1 There is generally follow-up within seven (7) working days if possible, and resident will be apprised of progress at least every 30 days for issues requiring comprehensive review or follow up until investigation and response completed.

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	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure pain was routinely assessed, and medication was given according to a physician's order for 1 (#3) of 23 sampled residents; this deficient practice had the potential for the resident to experience increased pain. Findings include:Review of resident #3's Quarterly MDS, with an accepted date of 4/21/26, showed: Section J (Health Conditions): .Pain presence Yes.Pain Frequency: 4 - Almost Constantly.Pain Effect on Sleep: 3 - Frequently.Pain Intensity: 3 - Severe.Review of resident #3's electronic health record showed: Physicians' orders: Hydrocodone-acetaminophen (5-325 mg/tab) (Norco) tablet., Dose: 1 tablet 3 times a day, start date of 4/9/26. Admin Instructions: Give with food, Diagnosis: Chronic Pain Syndrome, Time to Peak: oral 40-80 minutes, Duration: 4-8 hours, Route: oral. Additional Documentation. Flowsheets: .Pain Alert Assessment.Review of resident #3's medication administration record showed: Hydrocodone-acetaminophen (5-325 mg/tab) .- 4/14/26 at 1205 (12:05 a.m.) held not given. - 4/15/26 at 751 (7:51 a.m.) held not given, and 1943 (7:43 p.m.) held not given. - 4/16/26 748 (7:48 a.m.) held not given, and 1333 (1:33 p.m.) held not given.- 4/17/26 824 (8:24 a.m.) held not given, and 1318 (1:18 p.m.) held not given.Review of resident #3's electronic health record showed a pain assessment was completed on 4/16/26, which showed: Patient currently in pain. Yes, Pain Score (0-10), 7 -Severe, Pain Onset Ongoing.A pain assessment was completed again on 4/16/26 at 2130 (9:30 p.m.), which showed: Reassessment . Sleeping.No other pain assessments were completed for the dates of 4/14/26 to 4/17/26, when doses of pain medications were not given, which increased the resident's risk of pain.During an interview on 4/21/26 at 4:38 p.m., resident #3 stated her pain medications were recently changed, and she gets them most of the time every six hours.During an interview on 4/23/26 at 8:05 a.m., staff member V stated, We don't do a pain assessment on residents with scheduled pain medication. Staff member V stated if a staff member did do a pain assessment, it would be documented under vitals or in a progress note. Staff member V stated, The computer system automatically pops up a pain assessment even though we aren't required to do them for long-term care residents on scheduled pain medications. I wish they would fix that in the system.During an interview on 4/23/26 at 8:44 a.m., staff member C stated pain assessments should be conducted on each shift for anyone on pain medications. Staff member C stated the only time a pain medication should be held is if a resident is overly sedated and the side effects outweigh the benefits of the medication. Staff member C stated, Staff should always alert the physician if they hold a scheduled pain medication and consult them for further directions. Staff member C looked up resident #3's Medication Administration Record and was unable to identify why the medication was held between 4/14/26 and 4/17/26. Staff member C stated she did not know where the pain assessments were in the computer system and would need assistance locating them.During an interview on 4/23/26 at 9:58 a.m., resident #3 stated she always has pain that was eight out of ten, but she can deal with it when sitting. Resident #3 stated, I usually receive my pain medications as prescribed except when the nurse is too busy.Review of a facility document titled Pain Management Policy with an effective date of 5/9/25, showed: .Purpose: To provide a comprehensive approach to pain management that ensures effective, safe, and patient-centered care for all individuals experiencing pain, recognizing that pain is a vial factor in enhancing patient quality of life and health outcomes.Policy: 1. Pain Assessment: a. Conduct a comprehensive pain assessment for all patients, promptly and effectively, including the use of the enterprise's identified standard pain scales c. Document each pain assessment and reassessment in the patient's medical record.