STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER: Laurel Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 820 3rd Ave Laurel, MT 59044	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents were free from abuse and/or neglect for 5 (#s 7, 11, 18, 21, and 62) of 34 sampled residents. This deficient practice resulted in psychosocial distress for resident #7 feeling intimidated and scared to return to her room; on-going psychosocial distress with resident #11 feeling scared due to the physical and verbal abuse (with fear of a repeat event occurring with a fellow resident); resident #21 having her head hit the wall during peri care (with fear of a repeat event occurring); and neglecting to provide resident #s 7, 18 and 21 proper toileting care, which may have contributed to a urinary tract infection for resident #21. Findings include:1. During an observation and interview on 1/27/26 at 9:46 a.m., resident #11 stated on the night of 12/28/25, resident #62 came into her room, held her arms down, tried to get into her bed with her, and yelled, You know who I am, repeatedly at resident #11. Resident #11 stated, (She) screamed for help for quite some time, and no one came. Resident #11 showed her arms were held above her head, crossed, and held down. She stated she tried to hit resident #62, but that did not work. She stated she tried to hit him with her water cup next. She stated she would have hit him with her cane if she could have, but it was across the room. She stated resident #62 had been in her room two other times. Both times, resident #62 had urinated in her toilet and then left. Resident #11 stated she was scared and upset that this happened, and was fearful resident #62 would return to her room at night again and harm her. Resident #11 stated she was concerned he could potentially sexually assault her or make advances toward her. She stated she thought the facility had moved his room away from hers and was not aware resident #62 was still in the room next door. During an observation on 1/27/26 at 10:00 a.m., residents #11 and #62's rooms were located side by side in the hallway, rooms [ROOM NUMBERS]. During an interview on 1/28/26 at 8:59 a.m., staff members A and B stated they were able to find some staff statements from the Facility Reported Incident with residents #11 and #62. Staff members A and B stated they were unable to find any resident interviews on what occurred the night of 12/28/25. Review of a facility document, not titled and dated 12/28/25, showed: I [staff member V] CNA went to lunch at 2:20 a.m. I returned at 2:47 a.m. I went to my hall and found [Resident #62] in . (another resident's room) . [Resident #11]'s light was on, and she was yelling for help. She was very upset and said that a man was trying to get into bed with her, she also said that she hit him and yelled for help and threw water at him I noticed water all over the room. [sic] During an interview on 1/27/26 at 4:43 p.m., staff member R stated they never knew anything about the situation that occurred with resident #11 and resident #62 on 12/28/25. Staff member R stated (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they usually were in close communication with the physicians about any incidents that occurred in the facility. Staff member R stated they also did not know anything about resident #11's feelings and did not feel safe around resident #62. During an interview on 1/29/26 at 2:20 p.m., staff member A stated residents #11 and #62's rooms were not moved apart from one another prior to 1/28/26 because the facility was unaware that resident #11 felt unsafe. 2. During an interview on 1/26/26 at 4:20 p.m., resident #7 was crying while telling staff member J, who was pushing her to room, Please don't make me go in my room, I'm scared to go in there, please don't take me in there. Staff member J told resident #7 she could stay in the hallway. Resident #7 stated, I dread going in there, my roommate wants everything her way for her comfort, not mine. There is so much confusion in that room. It's depressing me, my roommate often uses the TV so loud I can't rest and gets mad when I go in the room. She always wants her needs to be the priority. Resident #7 stated she reported her concerns to CNAs and nurses, but no one listened to her. During an observation on 1/27/26 at 1:30 p.m., staff member I and J brought resident #7 to her room to toilet her. As the staff entered resident #7's room, the roommate yelled, Now what?! The roommate became agitated with the staff and resident #7. The two staff members explained to the roommate they were only in the room to toilet resident #7. The roommate growled at the staff and returned to her bed. Review of resident #7's Care Plan, with a revision date of 12/27/25, reflected resident #7 required dependent assistance with toileting, and transfers required the use of a Hoyer lift. Resident #7 was hard of hearing, had expressive aphasia, and depression. 3. During an interview on 1/26/26 at 4:41 p.m., resident #21 stated she often was left wet with a pad added to her brief at night so the staff would not have to change her brief so often. Resident #21 stated she was currently on antibiotics for a urinary tract infection because CNAs were not changing her during the night. Resident #21 stated staff kept hitting her head on the wall when changing her. Resident #21 stated she required a two-person assist for turning during the brief changes, but when they could not locate help, the staff would try to turn her alone, causing her pain and hitting her head on the wall repeatedly. Resident #21 stated the night CNA would answer her call light and say she would come back, but neglected to return, leaving resident #21 wetting herself and her bed, on 1/25/26. Resident #21 stated the CNAs came in and yelled at her and said, Why did you wet yourself? Resident #21 stated the CNA then added a pad to her brief and stated, I don't want to have to change you every two hours. Resident #21 stated she reported the care concerns to the nurse and CNAs the morning of 1/26/26, about the CNA yelling at her, neglecting to toilet her, the brief changes, and then placing a pad in her brief. Review of resident #21's Care Plan, with a revision date of 12/30/25, reflected resident #21 required maximal assist with toileting hygiene and required the use of a sit-to-stand for transfers. Resident #21 required care in pairs (two staff members for care). Resident #21's care plan reflected resident #21 was on an antibiotic for a urinary tract infection. Review of resident #21's MDS, dated [DATE], reflected resident #21 was on an antibiotic for a urinary tract infection. Review of the facility matrix, dated 1/27/26, reflected resident #21 was on an antibiotic for a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinary tract infection. During an interview on 1/28/26 at 2:02 p.m., staff member M stated resident #21 frequently reported a lot of concerns including staff neglecting toilet her or not using two people to change her brief causing her pain, her hitting her head on the wall, staff putting pads in her brief to avoid changing her, dietary complaints, call light times, and many more. Staff member M stated she reported resident #21's concerns to the nurse on duty when she heard them. 4. During an interview on 1/28/26 at 2:02 p.m., staff member M stated she arrived on shift on 1/26/26, and when she went to resident #18's room, she found him diagonally in his bed with his feet dangling off the bed. Staff member M stated it was about 9:00 a.m. when she found him. Staff member M stated resident #18 was soaked with urine from his shoes to his shoulders, his bed was soaked, and urine was pooling in the bed. Staff member M stated that resident #18 was still dressed in the same clothing from the day before. Staff member M stated the staff tried to get him up at 8:30 a.m., but he refused, so they left him there soaked. Staff member M stated that resident #18 did not have a history of soaking his bed. Staff member M stated it appeared resident #18 was neglected, left unattended all night, and the next morning without care. Staff member M stated resident #18 did not resist getting up and cares provided when she attempted to get him cleaned up. Staff member M stated she reported the incident to staff member L. Review of resident #18's MDS, dated [DATE], reflected resident #18 had a BIMS (Brief Interview of Mental Status) was a three (Severe problems with thinking and memory). Resident #18 required maximal assistance for toileting, maximal assist with dressing, and maximal assistance with walking. Resident #18 was noted to have incontinence of bladder and bowel. During an interview on 1/28/26 at 9:04 a.m., staff member L stated she frequently would receive complaints about resident cares on the night shift being neglected, including, [Resident #21's] concerns with staff not transferring her correctly, hitting her head on the wall because they only use one staff instead of two, hurting [Resident #21's] back with the way the CNAs would roll her in the bed, soaked beds, using pads in briefs, food preferences not met, medications not given on time were a few of the more common concerns reported. Staff member L stated she would re-educate the CNA staff when able, but often the staff were travel agency staff. Staff member L stated she did not report the care concerns to management because she felt education was the best option. During an interview on 1/28/26 at 2:13 p.m., staff member N stated she frequently came on shift to find residents in soaked beds. Staff member N stated the soaked beds were usually on the [NAME] Hall because [NAME] Hall required a lot of checks and changes. Staff member N stated she would report the neglected resident care and soaked beds to the nurse on duty or write up a grievance. During an interview on 1/28/26 at 2:20 p.m., staff member O stated she would commonly find residents neglected, including no oral care done, poor peri care, and soaked beds when she would come on shift. Staff member O stated resident #21 would complain staff were not putting her peri cream on, and that she was not getting her brief changed at night. Staff member O stated resident #7 was soaked on the morning of 1/26/26, and resident #7 did not have proper peri-care, causing the folds around her pannus to become red and inflamed. Staff member O stated she would report to her nurse or write a grievance, but usually nothing was ever done about it because most of the staff were travel staff. During an interview on 1/28/26 at 9:57 a.m., with staff members A and B, staff member A stated NF4 was no longer employed by the company, and many records were missing, including grievances and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigations. Staff member A stated she was not able to locate any grievances or complaints reported to management for residents #s 7, 18, or 21 for the concerns outlined above. Staff members A and B both stated they were not aware of resident #18 being soaked with urine, resident #21's concerns with toileting, pads in her briefs, hitting her head on the wall, or a CNA yelling at her, and they were not aware of resident #7's fear of her roommate until the surveyor brought the concerns forward. During an interview on 1/28/26 at 2:37 p.m., NF4 stated that grievances were the responsibility of the administrator, and she had no part in the grievances. NF4 stated that the only thing she did was to go out and interview residents if she was told to do so by the administrator. NF4 stated she did not know if grievances or complaints came in for residents #7, 18, or 21. Review of the facility policy, Abuse Reporting and Response, updated October 202, reflected: [sic] -The Center immediately reports all suspected and/or allegations of abuse, neglect, and exploitation of residents, misappropriation of resident property, mistreatment, and injuries of unknown source in accordance with state and federal law. 1. Staff immediately reports all alleged or suspected violations to the supervisor and Executive Director. . 3. Reports of alleged violations by others such as staff, residents, visitors, other healthcare providers, or others do not need to be explicitly characterized as abuse, neglect, mistreatment, or exploitation in order to require reporting, investigation, and further necessary steps. [sic] Review of a facility policy titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated 3/2025, showed: -Each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse ., -Mental Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Review of a facility policy titled, Abuse Policies and Procedures, dated 5/2025, showed: . Investigation: thorough investigation - Determine if the abuse, neglect, exploitation, and/or mistreatment has occurred and determine the extent and cause. Protection: Suspend and/or remove the alleged perpetrator from patient care area immediately. Protect residents from physical and psychosocial harm during and after an investigation.

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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 interview and record review, the facility failed to fully investigate an abuse allegation for 2 (#s 11 and 62) of 34 sampled residents. This deficient practice resulted in psychosocial distress for resident #11 who was feeling scared due to the physical and verbal abuse (with fear of a repeat event occurring with a fellow resident). Findings include: During an observation and interview on 1/27/26 at 9:46 a.m., resident #11 stated on the night of 12/28/25, resident #62 came into her room, held her arms down, tried to get into her bed with her, and yelled, You know who I am, repeatedly at resident #11. Resident #11 stated, (She) screamed for help for quite some time, and no one came. Resident #11 showed her arms were held above her head, crossed, and held down. She stated she tried to hit resident #62 but that did not work. She stated she tried to hit him with her water cup next. She stated she would have hit him with her cane if she could have but it was across the room. She stated resident #62 had been in her room two other times. Both times, resident #62 had urinated in her toilet, and then left. Resident #11 stated she was scared and upset that this happened and was fearful resident #62 would return to her room at night again and harm her. Resident #11 stated she was concerned he could potentially sexually assault her or make advances toward her. She stated she thought the facility had moved his room away from hers and was not award resident #62 was still in the room next door.Review of a facility policy titled, Abuse Investigation, updated 10/22, showed: . 2. The Center identifies and interviews involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.During an interview on 1/27/2026 at 3:52 p.m., staff members A and B stated they did not have staff or resident interviews for the Facility Reported Incident that occurred on 12/28/25 with residents #s 11 and 62.During an interview on 1/28/2026 at 8:59 a.m., staff members A and B stated they now were able to find some staff statements from the Facility Reported Incident with resident #s 11 and 62 (shown below). Staff member A stated they did not consider the incident with resident #s 11 and 62 to be abuse and this was why their rooms were still located next to each other (until it was brought to the facility's attention by the survey team). Staff member A stated the facility should have taken further action to investigate further which included staff and resident interviews, along with removing resident #11 from the potential abuse perpetrator during the investigation process.Review of a facility document, not titled and dated 12/28/25, showed: I [staff member V] CNA went to lunch at 2:20 a.m. I returned at 2:47 a.m. I went to my hall and found [resident #62] in . (another resident's room) . [Resident #11]'s light was on, and she was yelling for help. She was very upset and said that a man was trying to get into bed with her, she also said that she hit him and yelled for help and threw water at him I noticed water all over the room. [sic]