

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: 275111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
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 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure medications were free from unnecessary use by administering Narcan (naloxone) without a physician order or documented clinical indication for 1 (#4) of 1 resident reviewed for unnecessary medications. The failure resulted in precipitated opioid withdrawal symptoms, increased resident distress, and hospitalization, and the resident received additional medical treatment. Findings include: Review of a facility-reported incident submitted to the State Survey Agency on 5/18/26 showed resident #4, a hospice resident receiving comfort-focused treatment, was found unresponsive, and a staff member administered Narcan (naloxone). The report showed resident #4 was transported to the hospital related to a change in condition and monitoring for response to Narcan treatment. Review of resident #4's diagnosis list included diagnoses of chronic obstructive pulmonary disease (COPD), opioid dependence, anxiety disorder, chronic pain, and polyneuropathy. Review of resident #4's hospice admission orders showed the resident was admitted to hospice services on 2/24/26 for COPD and was prescribed morphine sulfate for comfort-focused symptom management. Review of resident #4's physician orders and medication administration records showed resident #4 was prescribed the following medications: - oxycodone hcl 5 mg every four hours as needed for pain, - fentanyl transdermal patch 50 mcg/hr every 72 hours, increased on 5/10/26 to 75 mcg/hr every 72 hours, - morphine sulfate 20 mg/ml dosing up to 20 mg per hour as needed for pain and shortness of breath. Review of resident #4's electronic health record did not show a physician order authorizing Narcan, or standing orders for Narcan use. During an interview on 7/29/26 at 3:10 p.m., staff member C stated there were no physician orders authorizing Narcan administration for resident #4. During an interview on 7/29/26 at 2:20 p.m., staff member G stated resident #4 had longstanding opioid use and required increasing pain medication for symptom management. During a telephone interview on 8/5/26 at 2:30 p.m., returned in response to a 7/29/26 interview request, staff member O stated resident #4's roommate notified her resident #4 was unresponsive. Staff member O stated she found resident #4 slumped near the edge of the bed and attempted to arouse her with a sternal rub. Staff member O stated, Coming from an ICU setting, it looked like an overdose to me, and staff member O retrieved Narcan nasal spray from the medication cabinet and administered to resident #4 without a physician order. Staff member O stated approximately five to ten minutes after the Narcan administration, resident #4 became more active, began flailing, and exhibited jerking movements of the upper extremities. Staff member O stated resident #4 appeared to be in respiratory distress, pushed the oxygen mask away, and was not following commands. Staff member O stated she called 911 and notified hospice after EMS arrived. Staff member O stated the hospice nurse told her Narcan should not have been administered. Review of the EMS patient care record, dated 5/17/26, showed the ambulance crew arrived at the facility at 7:47 p.m., and found the resident on the floor being held upright by staff and in obvious respiratory distress. The report showed the resident was gasping, unable to speak or follow commands, and (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 0757 Level of Harm - Actual harm Residents Affected - Few	exhibited exaggerated involuntary jerking movements. The EMS patient care record showed facility staff reported resident #4's blood pressure was 80/40 prior to their arrival, and hospital transport was delayed as the staff had not yet contacted hospice. The record showed resident #4 was transported from the facility utilizing lights and sirens at 8:25 p.m. The EMS patient care record documented findings were consistent with opioid withdrawal following Narcan administration. Review of hospice records, dated 5/17/26, included documentation that the facility nurse reported resident #4 received Narcan after receiving a fentanyl patch and morphine earlier that day. Hospice documentation showed Narcan was administered inappropriately. The hospice record also showed resident #4 convulsed, became restless, experienced labored breathing, was transferred to the emergency department, where she received multiple doses of lorazepam and morphine, was admitted to the hospital, and a morphine infusion was initiated. Review of the facility policy titled, Medication Ordering and Receiving from Pharmacy Provider, showed: 3.5 HOUSE-SUPPLIED (FLOOR STOCK) MEDICATIONS .5. Floor stock items are not to be administered without a current order from the resident's prescriber.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Facility-Reported Incidents were reported to the State Survey Agency within the required timeframe for 2 (#s 10 and 14), and failed to submit the results of investigations to the State Survey Agency within the required five-working-day timeframe for 9 (#s 4, 5, 9, 10, 11, 12, 13, 14 and 16) of 19 residents reviewed for Facility-Reported Incidents. The failures delayed the State Survey Agency's receipt of information necessary to evaluate the facility's response to allegations involving resident safety, placing residents at increased risk due to delayed regulatory oversight. Findings include: During an interview on [DATE] at 10:40 a.m., staff member A stated she was responsible for submitting both the initial reports and the investigative findings for all of the facility's reported incidents to the State Survey Agency within the required timeframes. Staff member A acknowledged several investigative findings were submitted late and stated, I'm still learning . there's been a lot going on here. 1. Review of a Facility-Reported Incident involving resident #14 showed the facility reported an allegation of neglect that occurred on [DATE]. Review showed the facility did not submit the required initial report to the State Survey Agency until [DATE], exceeding the required reporting timeframe. Review further showed the facility submitted the investigative findings to the State Survey Agency on [DATE], exceeding the required five-working-day reporting timeframe. 2. Review of a Facility-Reported Incident involving resident #10 showed the facility reported an allegation of verbal abuse that occurred on [DATE]. Review showed the facility did not submit the required initial report to the State Survey Agency until [DATE], exceeding the required reporting timeframe. Review further showed the facility submitted the investigative findings to the State Survey Agency on [DATE], exceeding the required five-working-day reporting timeframe. 3. Review of a Facility-Reported Incident submitted to the State Survey Agency on [DATE] showed the facility reported an allegation of resident-to-resident verbal abuse involving resident #9 and resident #16. The incident occurred on [DATE]. Review showed the investigative findings were submitted to the State Survey Agency on [DATE], exceeding the required five-working-day reporting timeframe. 4. Review of a Facility-Reported Incident submitted to the State Survey Agency on [DATE] showed the facility reported the unauthorized administration of Narcan to resident #4. The incident occurred on [DATE]. Review showed the investigative findings were submitted to the State Survey Agency on [DATE], exceeding the required five-working-day reporting timeframe. 5. Review of a Facility-Reported Incident submitted to the State Survey Agency on [DATE] showed the facility reported an incident involving cardiopulmonary resuscitation (CPR) initiated for resident #12 when a POLST was not readily available. The incident occurred on [DATE]. Review showed the investigative findings were submitted to the State Survey Agency on [DATE], exceeding the required five-working-day reporting timeframe. 6. Review of a Facility-Reported Incident submitted to the State Survey Agency on [DATE] showed the facility reported an allegation of staff-to-resident abuse involving resident #11. The incident occurred on [DATE]. Review showed the investigative findings were submitted to the State Survey Agency on [DATE], exceeding the required five-working-day reporting timeframe. 7. Review of a Facility-Reported Incident submitted to the State Survey Agency on [DATE] showed the facility reported an allegation of resident-to-resident verbal abuse involving resident #5 and resident #13. The incident occurred on [DATE]. Review showed the investigative findings were submitted to the State Survey Agency on [DATE], exceeding the required five-working-day reporting timeframe. Review of a facility policy titled, Abuse Reporting and (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Response, last updated [DATE], showed:Policy Statement. 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 .The Executive Director or designee reports alleged violations to the State Survey Agency and other officials in accordance with state law .The Center reports the results of all investigations to the Executive Director and to other officials, in accordance with state law, including to the State Survey Agency, within five working days of the incident.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to provide timely toileting and activities of daily living (ADL) assistance for 3 (#s 2, 5, and 6) of 6 sampled residents who required staff assistance with toileting and personal care. The failure resulted in resident #2 remaining on the toilet for a prolonged period and residents #5 and #6 not receiving required toileting and ADL assistance, placing the residents at risk for discomfort, loss of dignity, unmet care needs, pain, skin impairment, and injury. Findings include:1. Review of a Facility Reported Incident, submitted to the State Survey Agency on 4/22/26, showed resident #2 was reported to have been left unattended on the toilet for approximately 30 minutes.Resident #2:During an interview on 7/28/26 at 3:12 p.m., NF3 stated he recalled the incident when resident #2 was left in the bathroom because he was very upset. NF3 stated resident #2 remained on the toilet for nearly two hours, not approximately 30 minutes as reported by the facility, and had been calling out for help. NF3 stated resident #2 tried to get himself off the toilet because he was getting so sore and managed to get to his seated walker. He was then able to hit the call light but could not do anything more. NF3 stated resident #2 was cognitively very good. Once in a while he would repeat a question, but he was very aware of what was going on. NF3 stated resident #2 was unable to reach the call light while seated on the toilet because of his limited mobility, and staff was aware he could not reach the call light when they placed him on the toilet. NF3 stated resident #2 had little to no muscle tone at that point, and trying to hold himself up in that position for all that time; that was hard on him. NF3 stated resident #2 told him he had been calling out for help and . finally a nurse heard him and came in and helped him. NF3 stated resident #2 did not have open wounds from sitting all that time but was very sore for several days afterward.During an interview on 7/29/26 at 3:22 p.m., staff member G stated, Residents should never be left on the toilet more than five minutes because they can fall. Staff member G stated CNAs should remain nearby to hear when the resident was ready to be removed from the toilet. Staff member G stated, It can depend on the resident, though; I know my residents and how long they usually are in the bathroom. Staff member G further stated, Thirty minutes is too long and can cause skin breakdown and can make it hard for the resident to stand with assist after sitting too long.During an interview on 7/29/26 at 3:40 p.m., staff member F stated she did not like to leave her residents' rooms when they were on the toilet and said, That is when injuries happen. It is easy to get pulled away to help another CNA or resident, and then your resident on the toilet is at risk. I am very protective of my residents. Staff member F stated 30 minutes on the toilet would be excessive.During a telephone interview initiated during the survey period, with a return call on 8/5/26, staff member H stated resident #2 was independent in the bathroom and often only needed assistance with his belt buckle while dressing. Staff member H stated she did not assist resident #2 to the bathroom on the day of the incident. Staff member H stated resident #2 was able to use his walker to go to the bathroom independently and would often remain in the bathroom for long periods of time. Staff member H stated resident #2 was able to clean himself after toileting and could reach the call light in the bathroom if needed.Review of a facility-provided written statement from staff member I showed, . When I entered resident #2's room, he was sitting on his walker without pants on. He asked if I could help him . It appeared he moved from the toilet to the walker without being cleaned . This took place around 12:00 p.m., I believe.Review of the facility's investigation of the incident, dated 4/22/26, showed staff member H stated she assisted resident #2 to the toilet at approximately 11:30 a.m. The investigation did not identify why staff member H failed to return to assist resident #2 off the toilet in a timely manner, and no written statement from staff member H was included in the investigative file.Review of resident (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#2's diagnosis list showed diagnoses included low back pain, constipation, and overactive bladder. Review of resident #2's Quarterly MDS assessment, with an assessment reference date of 5/16/26, showed resident #2 was dependent on staff for toileting and toileting hygiene, requiring moderate to maximal assistance, and required supervision or touch assistance for toilet transfers. Review of resident #2's care plan, initiated on 11/23/25 and revised on 4/19/25, showed he was at risk for falls and had a previous fall. The care plan did not show any fall interventions related to bathroom safety. 2. Review of a Facility Reported Incident, submitted to the State Survey Agency on 6/19/26, showed the facility reported an allegation of neglect after residents #5 and #6 did not receive required toileting and activities of daily living assistance during the day shift on 6/12/26. Resident #5: Review of the facility's investigation, dated 6/19/26, showed the allegation was substantiated. The investigation concluded the assigned CNA failed to provide the required toileting and ADL assistance to resident #5 during the day shift on 6/12/26. During an interview on 7/29/26 at 4:38 p.m., staff member F stated CNAs are expected to check and change dependent residents at least every two hours, and sooner if needed. During an interview on 7/29/26 at 5:15 p.m., resident #5 stated she filed a grievance about the CNA who never came back to help me. Resident #5 stated NF2 repeatedly told her she would return to clean her up but never did. Resident #5 stated, She (NF2) doesn't work here anymore. Review of resident #5's diagnosis list showed diagnoses including metabolic encephalopathy, anxiety disorder, multiple vertebral fractures, cerebrovascular accident, and polyneuropathy. Review of resident #5's Quarterly MDS assessment, with an assessment reference date of 6/22/26, showed a BIMS score of 15; cognitively intact, complete dependence on staff for toileting hygiene, and maximal assistance for personal hygiene. Review of resident #5's care plan showed interventions, last revised 5/21/26, for pain related to wounds and chronic back and lower extremity discomfort, and interventions, last revised 7/1/26, for frequent urinary incontinence. Resident #6: During an interview on 7/29/26 at 5:40 p.m., resident #6 stated he recalled the incident (on 6/12/26) stating, . I wasn't changed, and I wasn't even asked if I wanted to get up. During an interview on 7/29/26 at 3:55 p.m., staff member M stated, We check on every resident at least every two hours all day long and change them as needed; no exceptions. They need that, or they can get skin breakdown. I would definitely report to the Director of Nursing if another CNA was not caring for their residents. Review of resident #6's diagnosis list showed diagnoses including chronic obstructive pulmonary disease, heart failure, cognitive communication deficit, and wheelchair dependence. Review of resident #6's care plan showed interventions revised on 4/10/26 for maximal assist from staff for toileting hygiene and bladder incontinence, and interventions revised on 8/15/25 for moderate assist for personal hygiene and dependence on staff for wheelchair locomotion. Review of resident #6's Quarterly MDS assessment, with an assessment reference date of 6/8/26, showed a BIMS score of 9 for moderate cognitive impairment; moderate to maximal assistance required for toileting and personal hygiene and moderate assistance required for repositioning. Review of NF2's written statement, undated, showed NF2 stated she checked on residents #5 and #6 every two hours, but they did not want to be changed and did not want to get up. Review of staff member N's written statement, dated 6/12/26, showed residents #5 and #6 stated they had not been changed, and when they requested assistance, NF2 repeatedly stated she would return but did not. Staff member N's written statement showed both residents were saturated with urine when she provided their care at approximately 3:00 p.m. Review of the facility's investigation, dated 6/19/26, showed the allegations for resident #s 5 and 6 were substantiated. The investigation concluded the assigned CNA failed to provide the required toileting and ADL assistance to residents #5 and 6 during the day shift on 6/12/26. A request was made on 7/30/26 for the facility's policies regarding toileting assistance and activities of daily living. The requested policies were not provided by the end of the survey.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review, the facility failed to ensure an effective system for timely reporting of allegations of abuse and neglect following a previous F609 deficiency for the same concern. The facility's continued failure to timely report allegations after implementing corrective measures demonstrated ineffective administrative oversight and failure to implement, monitor, and sustain the reporting process for 9 (#s 4, 5, 9, 10, 11, 12, 13, 14 and 16) of 19 residents. The failure placed residents at risk for delays in notification, investigation, protection, and response following allegations of abuse or neglect. Review of the facility's previous F609 deficiency dated 1/29/26 showed the facility was cited for late reporting for allegations of neglect and abuse for three residents. The facility submitted a plan of correction for the deficient practices identified. During an interview on 7/29/26 at 10:40 a.m., staff member A stated, I'm still learning . there's been a lot going on here . The administrator further stated, . I need to develop a system, so I know when they are due. Review of the facility's Plan of Correction for the previous F609 deficiency cited during the 1/29/26 survey showed, Administrator was educated on 1/31/26 by Executive Director using abuse policy which included: Definitions of abuse, screening, training, prevention, identification, investigation, protection, reporting and response, and coordination with QAPI. Administrator or designee will educate all staff on the abuse policy by 2/22/2026. The Administrator or DON will audit risk management reports, grievance forms, and clinical progress notes as needed in addition to oral reports of allegations of abuse as problems are identified. The [Facility Corporation] Abuse Critical Element Pathway will be used as an audit tool to ensure all components for abuse reporting, protection, and investigation are met for all allegations. Critical Element Pathways will be reviewed at QAPI monthly and by Interdisciplinary team as needed in between QAPI meetings for three months to identify any issues and ensure continued compliance. The facility's period of interdisciplinary team monitoring for continued compliance was 2/22/26 through 5/22/26. The current complaint investigation showed the facility administrator and staff continued to report allegations of abuse or neglect throughout the plan of correction monitoring period, with eight of the nine late reports identified during the complaint investigation as occurring between 2/22/26 and 5/22/26. Despite the facility's previous F609 deficiency and implementation of corrective measures, nine additional late reports were identified. The recurrence of the same or similar reporting failure demonstrated that the facility's administrative oversight was not effectively overseeing the abuse reporting process or implementing measures to prevent deficient practices and sustain the corrections for ongoing compliance. Review of the State Survey Agency's information for the facility showed staff member A took over the Administrator position as of 5/19/25, and obtained the Administrator's license on 12/19/19. A review of the Montana Code Annotated, 2025, Title 52, Chapter 3, Part 8, shows a mandatory person includes (not all inclusive): (e) a person who maintains or is employed by a roominghouse, retirement home or complex, nursing home, group home, adult foster care home, adult day-care center, or assisted living facility or an agency or individual that provides home health services or personal care in the home;		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a system to ensure a resident's current Physician Orders for Life-Sustaining Treatment (POLST) form was immediately available to staff during a medical emergency for 1 (#12) of 5 sampled residents reviewed for advance directives. The failure resulted in CPR being initiated despite the resident's documented wishes to forgo resuscitation. Findings include: Review of a facility-reported event showed resident #12 experienced a cardiac arrest on [DATE]. Nursing staff initiated cardiopulmonary resuscitation (CPR) after they were unable to locate the resident's POLST documenting a Do Not Resuscitate (DNR) order. The event documentation showed CPR was discontinued after EMS arrived and the resident's son confirmed the resident had a completed POLST directing no resuscitation. During an interview on [DATE] at 2:30 p.m., NF1 stated he provided the resident's signed POLST to the facility at the time of admission. He stated he believed the facility had the document and expected staff would honor his mother's wishes. NF1 stated facility staff called him while CPR was in progress because they could not locate the POLST. He stated, I gave it to you when I came. You need to stop. NF1 stated he was saddened his mother underwent CPR despite her documented wishes to decline resuscitation. During an interview on [DATE] at 2:55 p.m., staff member K stated admission documents, including signed POLST forms, were forwarded to the medical records department for scanning into the electronic health record. She stated the original POLST was not maintained on the nursing unit during the scanning process. Staff member K stated the time between receipt of the POLST and availability in the electronic health record ranged from a couple of days to a couple of weeks, depending on the volume of records awaiting scanning. She stated the resident's POLST was located in the medical records office a few days after the event. During an interview on [DATE] at 3:02 p.m., staff member O stated she assisted in locating the resident's POLST on the evening of the event. She stated staff were unable to locate the document in the resident's electronic health record and initiated CPR because the resident's code status could not be verified. During an interview on [DATE] at 3:10 p.m., staff member G stated the facility used the code status documented in the hospital discharge orders to establish a resident's code status when a resident was admitted without a signed POLST. During a telephone interview on [DATE] at approximately 4:15 p.m., staff member B stated the facility's process at the time of the incident contributed to the failure to ensure the POLST was available in the electronic health record when needed. Staff member B stated the facility implemented changes after the [DATE] event to improve the visibility and accessibility of POLST forms within the electronic health record. Review of resident #12's electronic health record showed a hospital discharge referral, dated [DATE], documented the resident's code status as DNR (Do Not Resuscitate) and showed a signed POLST accompanied the referral documents. Review of the admission paperwork showed a completed POLST, dated [DATE], and an Advance Directive, dated [DATE], were included with the admission documents. Review of a facility document titled Advanced Directive, last revised on [DATE], showed: Policy Statement: It is the policy of this facility that residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive .2. During the admission process, the facility identifies if the resident has an advance directive or medical orders related to life-sustaining treatment. If the resident does, a copy is requested and kept in the resident's medical record, accessible to the physician and care staff .		

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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 observation, interview, and record review, the facility failed to thoroughly investigate allegations of abuse and neglect for 1 (#3) of 9 sampled residents reviewed for abuse or neglect. The failure resulted in an incomplete investigation that did not demonstrate the facility adequately evaluated the allegation, determined the facts, or documented findings and corrective actions, placing residents at risk for unaddressed abuse and inadequate protection. Findings include: Review of a Facility Reported Incident, submitted to the State Survey Agency on 7/15/26, showed the facility reported an allegation of verbal abuse involving resident #3. The report included documentation of concerns that two night shift staff members were not gentle with care, and one staff member was described as sour (unfriendly disposition). During an observation and interview on 7/29/26 at 7:17 a.m., resident #3 was observed lying in bed. Resident #3 stated, Some people here aren't very nice . I do feel safe here. Resident #3 did not remember the specific incident. During an interview on 7/29/26 at 5:05 p.m., staff member A stated she was responsible for making sure the investigation documentation was complete and timely. Staff member A stated she could not locate additional investigative documentation for this incident, and stated, There is so much to learn here. Review of resident #3's Quarterly MDS assessment, with an assessment reference date of 6/8/26, showed resident #3 had a BIMS score of 13, reflecting intact cognition. Review of the investigative summary documentation from the Bounds system (abuse/incident reporting system) showed the investigation included initiation of 72-hour psychosocial monitoring and a follow-up interview with resident #3, during which resident #3 stated she felt safe. Review of the Facility-Reported Incident investigative file provided by the facility did not include documentation supporting interviews with the accused staff members, other residents, witnesses, or staff identified as knowing about the allegation. The investigative documentation available for review also did not include records supporting the facility's investigative findings. Although the facility reported that these investigative activities and actions had occurred, supporting documentation was not included in the investigative file provided to the surveyor for review. Review of resident #3's electronic health record did not show documentation of the 72-hour psychosocial monitoring referenced in the investigative documentation. A request was made on 7/28/26 for the complete investigative file. No additional investigative documentation was provided by the end of the survey.		

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 07/30/2026
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 0689 Level of Harm - Minimal harm or potential for 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 failed to provide supervision and assistance during bathing and transfers consistent with the resident's assessed needs and care plan for 1 (#14) of 3 residents sampled for falls. The failure resulted in resident #14 falling forward from a shower chair, placing the resident at risk for injury. Findings include: Review of a Facility-Reported Incident submitted to the State Survey Agency on 2/10/26 showed resident #14 sustained a fall on 2/2/26 at approximately 7:45 a.m. after completing a shower. Documentation showed the resident stated he attempted to dry his feet while seated in a shower chair and slipped from the chair onto the floor. The resident was assessed immediately following the fall, and no injuries were reported. During an interview on 7/29/26 at 3:59 p.m., staff member M stated resident #14 had several falls while he was here (at facility). Staff member M stated, For this fall, [resident #14] had been brought back to his room in the shower chair. The shower aide left the room to get some clean towels or gown, and when he came back, the resident had fallen off the shower chair and was on the floor. Staff member M stated residents should never be left alone in a shower chair because the chair is not stable and may be wet and slippery. Review of resident #14's nursing progress note, dated 2/2/26, showed: . Nurse finds resident side lying on the ground, shower chair behind him. Resident states, 'I was trying to dry my feet and fell forward.' . Resident has no c/o. Review of resident #14's diagnosis list showed diagnoses including CVA with hemiparesis, epilepsy, and traumatic brain injury. Review of resident #14's care plan, updated on 3/30/26, showed the resident had a history of falls and remained at elevated risk for falls. The care plan did not show interventions prior to the resident's fall related to needing standby assistance at all times. Review of the facility's investigation for resident #14's fall from the shower chair, completed 2/18/26, showed resident #14 required maximum assistance for transfers according to the resident's care plan. The investigation determined the shower chair was functioning properly and no environmental hazards were identified. The investigation further concluded the supervision and assistance provided during bathing did not align with the resident's assessed needs or care plan and that this variance from established bathing and transfer safety procedures contributed to the resident's fall.		

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NAME OF PROVIDER OR SUPPLIER Laurel Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 820 3rd Ave Laurel, MT 59044	
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmacy services that ensured stock emergency medications were obtained, available, and administered only as authorized by physician orders for 1 (#4) of 1 resident reviewed for pharmacy services. The failure increased the risk residents could receive emergency medications without appropriate authorization or clinical indication. Findings include: Review of a facility-reported incident submitted to the State Survey Agency on 5/18/26 showed resident #4, a hospice resident receiving comfort-focused treatment, was found unresponsive, and the nurse administered Narcan (naloxone). Review of resident #4's electronic health record did not show a physician order authorizing Narcan. The electronic health record also lacked nursing documentation identifying that Narcan was administered, the dose, route, time of administration, the indication for use, source of the medication, or the resident's response to the Narcan. During a telephone interview on 8/5/26 at 2:30 p.m., following a voice mail request for interview on 7/29/26, staff member O stated she retrieved Narcan nasal spray (2mg) from the medication cabinet because, I knew she was on hospice, but coming from an ICU setting, it looked like an overdose to me (referring to resident #4's status at the time of the event). Staff member O stated she did not obtain a physician order before administering the medication. Staff member O stated she did not sign the medication out of the stock medication cabinet because she didn't really see anywhere to do so, and stated, With [Agency name] shifts you get like 10 minutes orientation. During an interview on 7/29/26 at 2:45 p.m., staff member A stated she was unable to locate standing physician orders authorizing Narcan administration. During an interview on 7/29/26 at 3:10 p.m., staff member C stated there were no physician orders authorizing Narcan administration, and the facility did not maintain standing physician orders for Narcan. Staff member C stated the medication may have been obtained from the facility's emergency medication kit. During a telephone interview on 7/30/26 at 8:49 a.m., staff member D stated the facility had never maintained standing physician orders authorizing Narcan administration. Staff member D stated, It might be a good idea, though. Review of email documentation provided by the facility following the survey showed communication between the contracted pharmacy and the facility regarding the development and implementation of protocols that were not previously in place for access to and use of the emergency kit (e-kit) medications and house-supplied stock medications related to Narcan administration. Review of facility education documentation, titled, Narcan (Naxalone) Administration in Hospice Residents, dated 5/18/26 to 5/20/26, showed: Before administering Narcan, the nurse must first verify a current physician/provider order and review goals of care. Review of the facility policy titled Medication Ordering and Receiving from Pharmacy Provider, dated 1/25, showed: . 3.4 EMERGENCY PHARMACY SERVICE AND EMERGENCY KITS (E-KITS) POLICY .7. When an emergency or stat medication is needed, the nurse first verifies and reviews the prescriber's orders for appropriateness, checks the resident's allergies, and removes the required non-controlled medication from the emergency kit. Emergency medications are only administered with a valid prescriber's order.		