STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275111	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Health & Rehabilitation Center	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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to utilize and maintain a QAPI system to identify performance improvement issues related to grievances, abuse and neglect allegations, Bowel and Bladder care for dependent residents, and infection control; and failed to show how the QAPI committee was involved in addressing these quality of care issues and the lack of policies and procedures which could negatively affect many, or all, of the residents residing at the facility. Findings include:During an interview and record review on 1/28/26 at 2:45 p.m., staff member A stated the facility met monthly to discuss any concerns the department managers had. Staff member A stated the department managers did not bring data to the meetings. Staff member A stated the meeting was, more of a conversation type meeting where the managers can bring their issues in their department forward and we talk about ideas to resolve them. Staff member A stated the departments do not present on trends based on data. Staff member A stated the QAPI group did look at customer satisfaction surveys and Quality Measures. Staff member A did not have minutes, or documentation to present for the last QAPI meeting. Staff member A stated the QAPI group had not discussed concerns around abuse and neglect, grievances, infection control, or antibiotic stewardship. Staff member A stated the Infection Preventionist discussed any concerns she had but no data was presented to evaluate for trends. Staff member A did not have any root-cause analyses to review for areas of concern. Staff member A stated the facility did not have any performance improvement plans for the past twelve months. Review of the facility's, Appendix 4A: QAA Committee Agenda and Attendance Sheet, dated February 2018, reflected seven primary areas of data presentation with 49 specific items to be covered, including resident satisfaction, employee satisfaction, education and training, quality care, operational quality, and PPS trends. 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:- . Neglect . Staff repeatedly ignoring resident's needs for assistance with ADLs, resulting in residents . being left in fecal material or urine. 8. Coordination with QAPI, The Center has written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program.Review of the facility's, QAPI Plan, updated October 2018, reflected:- . Improvement changes and decisions are based on data and measurements versus opinions and ideas. The Center collects data that is accurate, reliable, and valid for the area of focus.

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to have an annual improvement project that focuses on high risk or problem-prone areas identified through the data collection and analysis. Findings include: During an interview and record review on 1/28/26 at 2:45 p.m., staff member A did not have minutes, or documentation to present for the last QAPI meeting, only an agenda/attendance sign in sheet. Staff member A stated the QAPI group had not discussed concerns around abuse and neglect, grievances, infection control, dental needs, bathing, activities for disabled residents, care planning, or antibiotic stewardship. Staff member A stated the facility did not have any performance improvement plans for the past twelve months.Review of the facility's, QAPI Plan,, dated October 2018, reflected:- . The Quality Assurance (QAA) Committee oversees the Center QAPI program. They are tasked with identifying areas requiring performance improvement, collecting data, developing and implementing corrective action, and creating monitors to determine and validate changes are effective and sustained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to ensure infection control practices were followed when providing incontinence care for 1 (#21); hand hygiene practices were followed for 1 (#7); posted PPE requirements were followed for 1 (#21); transporting of dirty linens; storage of clean linens; and maintained cleanable surfaces for 34 sampled residents. These deficient practices place all residents at increased risk of infection. Findings include: 1. 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. Resident #21 stated one CNA always wiped from back to front and right after she worked, she developed the E. Coli urinary tract infection.During an observation and interview on 1/27/26 at 1:30 p.m., staff member K was assisting resident #21 off the toilet and cleaning her peri-area and anus. Staff member K entered and began cares without wearing appropriate PPE for Enhanced-Barrier Precautions. Staff member K put on gloves, and began cleaning resident #21's anus, using multiple wipes from behind the resident while she stood up. Staff member K did not clean resident #21's vaginal or front area. Staff member K pulled resident #21's brief and pants up and assisted her back to her wheelchair. Afterwards, staff member K was asked about the Enhanced-barrier Precautions sign on the room door. Staff member K stated, Hum, and shrugged his shoulders. When asked about cleaning resident #21's front peri-area, staff member K stated, Well, she's big so I can't really reach through from the back, but I try a little. Review of resident #21's,Care Plan, revision date 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 cares in pairs (two staff members for care). Resident #21's care plan reflected resident #21 was on an antibiotic for a urinary tract infection. Resident #21's care plan also reflected: Follow Enhanced Barrier Precautions posted at my door, r/t lower extremity wounds when high contact care is being provided in resident room.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 not changing her brief and putting pads in her brief. 2. During an observation and interview on 1/27/26 at 1:30 p.m., staff member I and J brought resident #7 to her room to toilet her. Staff member I and J completed hand hygiene and put on gloves. Staff member I was running the sit-to-stand while staff member J was assisting to remove resident #7's soiled brief. Resident #7 stated she was finished toileting, and staff member J began to clean resident #7 from front to back. Staff member J stopped and changed her gloves without hand hygiene. Staff member J then assisted resident #7 to put on a clean brief and redress. Staff member J did not complete hand hygiene between dirty and clean tasks. Afterwards, staff member J stated she forgot to complete hand hygiene before putting on new gloves.3. During an observation on 1/27/26 at 12:25 p.m., staff member I was noted to be carrying dirty linen down the hall up against her body, not bagged and touching her scrub top. 4. During an observation and interview of the laundry facilities on 1/27/26 at 10:42 a.m., with staff member P found the clean bagged pillows were being stored in the dirty linen room on a shelf next to dirty linen bins. Staff member P stated the staff should not be storing clean items in the dirty linen, including the clean pillows. Staff member P stated he was unable to locate audits or documentation of the Infection Preventionist completing rounds of the laundry area or storage rooms.5. During an observation and interview of the storage rooms on 1/27/26 at 10:45 a.m., with staff member P the following was noted:- Two boxes of nasal cannulas on the floor,- A box of Trach tubes on the floor,- A full shelf of ABD pads one inch off the floor, - Two boxes of lidocaine patches on the floor,- Five catheter bags on the floor,- Clean towel blankets stored on a full shelf from the floor to the ceiling five inches away from the bathtub and uncovered,- Nutrition room counter was waterlogged and no longer a cleanable surface, and- Nutrition room linoleum mat on floor was cut four cm short down two walls exposing unfinished flooring, and a hole in the mat in front of the refrigerator was twelve cm by four cm in size, exposing an uncleanable surface. Review of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility's, CNA Competency-Peri-Care, Female, updated May 2015, reflected: . 10. Separate the labia, clean the area using one downward stroke (front to back). Do not wipe the same area of the washcloth/wipe for more than one pass.14. Apply soap to newly mitted washcloth or wipe. Clean the rectal/peri-area from the vagina to the anus in one downward wipe.Review of the facility's policy, Handwashing/Hand Hygiene, updated August 2025, reflected:- . Examples of situations when hand hygiene is performed, includes but is not limited to: . d. Before and after assisting a resident with personal care activities. (e.g. oral care, incontinent care, dressing, grooming, bathing). and . r. After removing gloves.Review of the facility's policy, Soiled Laundry and Bedding, dated May 2015, reflected:- . 2. Place contaminated laundry in a bag or container at the location where it is used and do not sort or rinse at the location of use.13. Clean laundry is not stored with dirty or soiled laundry. b. Clean linen is stored in a room or cart that has a cover over the clean linens to prevent contamination while waiting to be used.Review of the facility's policy, Personal Protective Equipment (PPE) Work Practices, updated May 2015, reflected:- . 1. Employees are required to use PPE in accordance with Standard and Transmission-Based Precautions, as defined by the Centers for Disease Control.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement and maintain an antibiotic stewardship program in order to promote the appropriate use of antibiotics. This deficient practice increased the risk for residents to develop drug-resistant organisms and/or complications. Findings include:During an interview and record review on 1/28/26 at 2:40 p.m., staff member P stated the facility Infection Preventionist was not available during the week of the survey. Staff member P reported the facility did not have an antibiotic stewardship program in place. Staff member P stated the Infection Preventionist tracked infections but did not address specific laboratory results and sensitivity of infectious agent to the antibiotic ordered by the physician. Staff member P was not able to locate an antibiogram or audits for the infections. Resident #21 reported she was being treated for a facility acquired E. Coli urinary tract infection. Refer to F880. Review of the facility's Line Listing for Infections by Resident, dated 10/1/25, reflected 40 percent of the infections for the month of October were urinary tract infections. Review of the facility's Infection Preventionist Job Description, updated March 2025, reflected:- .9. Directs antibiotic stewardship activities within the community to inform strategies to improve antibiotic use by tracking antibiotic doses, adherence to evidence-based published criteria, and reviewing antibiotic resistance patterns in the community.Review of the facility's policy, Antimicrobial Stewardship Program (ASP), updated March 2018, reflected:- .d. Infection Preventionist: Monitors and supports ASP activities through rounds, audits, review of physician/provider orders, documentation, and available Antibiogram, pharmacy reports, and clinical reports. Reviews antibiotic resistance patterns: i. Monitors HAI MDRO's on monthly line listing, center map, and infection control report looking for increased rates and/or trends. ii. Compares Center Antibiogram for commonalities with reports.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to provide evidence to show the facility took action to acknowledge and resolve, or attempt to resolve, all concerns brought forth by the resident council. The failure affected any resident who had concerns that remained unresolved, or who had an interest in the council's activities. Findings include:During an observation of the facility's Resident Council meeting on 1/28/26 at 11:01 a.m., staff member C was observed asking the residents, How are things going? Staff member C did not read aloud the previous meeting minutes and did not follow up on the previous month's concerns. Unidentified residents in attendance reported ongoing and unresolved concerns with missing laundry, meals being served cold, and call lights not being answered in a timely manner.During an interview on 1/28/26 at 11:59 a.m., staff member C stated she had recently been assigned as the resident council's staff liaison. Staff member C stated she transcribed the Resident Council's meeting minutes and would follow up with departments in which residents voiced concerns. Staff member C stated the follow-up with the department was verbal and was not provided in writing. Staff member C stated she did not file a grievance form. Staff member C stated she would then follow up with the residents at the next scheduled monthly meeting to see if their concerns had been resolved.During an interview on 1/28/26 at 1:00 p.m., staff member A stated that facility grievance forms were unavailable for the period 10/7/25 through 1/25/26, and 21 grievances during the period of 6/12/25 through 10/7/25 had not been investigated. Staff member A stated NF4 had been responsible for the grievances and no longer worked at the facility. Staff member A stated that the day after NF4 left, everything (documents) from her office was gone. While she was employed, NF4 would collect the grievances from the grievance box and would bring the grievances to her immediately for review. Staff member A stated she did not know why the 21 grievances completed by residents between 6/12/25 and 10/7/25 had not been investigated, or a written response provided to residents.During a telephone interview on 1/28/26 at 2:37 p.m., NF4 stated that during her time employed by the facility, she received an average of three grievances a week and turned them into staff member A. NF4 stated she was not in charge of collecting the grievances from the grievance box and did not know how many would be in the grievance box a week. NF4 stated that the three grievances she received a week ago were not from the grievance box. NF4 stated she received and turned in at least 15 grievances from 11/1/25 to 12/31/25. A review of the Resident Council meeting minutes, dated January 2025 through January 2026, showed the Resident Council had discussed the following concerns, which would have required follow-up and resolution:On 4/21/25, the Resident Council discussed concerns regarding late medications, CNA's not providing snacks or coffee on request, long call light times, incontinence care, food and coffee palatability, meal tickets being missed for food orders, and spicy food served multiple days in a row.On 5/19/25, the Resident Council discussed concerns regarding long call light times, long wait times for bathroom assistance, poor food palatability, missing or incorrect laundry, and garbage bins not being emptied.On 6/23/25, the Resident Council discussed concerns regarding long call light times, staff playing on phones and not answering call lights, cold food, delayed food delivery, poor food palatability, lack of available coffee at 6:00 a.m., missing or incorrect laundry, and garbage bins not being emptied.On 7/24/25, the Resident Council discussed concerns regarding long call light times, delayed food delivery, poor food palatability, lack of available coffee at 6:00 a.m., missing or incorrect laundry, and poor room cleaning.On 8/18/25, the Resident Council discussed concerns regarding grievance forms not being responded to, staff not completing assigned tasks, limited administration contact, prolonged call light times, smaller portion sizes, staff not reviewing or following resident slip menus, frequent serving of beans and rice, poor food palatability, and incorrect laundry delivery.In November 2025 (date not specified), the Resident Council discussed concerns regarding call light response times and missing laundry items.On 12/15/25, the Resident Council discussed concerns regarding food temperature, CNAs not warming food on request, CNA care concerns, long call light times, laundry not (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being picked up consistently, and incorrect laundry delivery.On 1/19/26, the Resident Council discussed concerns regarding availability of CNA staff for care, CNA care concerns, food temperature, poor housekeeping, missing and incorrect laundry delivery, TV or bed controls, and wheelchairs left out of reach.Review of the facility's Grievance Forms received, dated 6/12/25 - 1/26/26, reflected:- No grievance forms from 10/8/25 through 1/26/26, and- 21 of 39 Grievance forms received and reviewed by the survey team contained complaints from residents, but no investigation, resolution, or person notified of a resolution was documented on the form. There was no grievance identified as being submitted related to resident council concerns.Review of a Center Grievance Official sign, which was posted publicly, updated March 2025, reflected that staff member A was the grievance Official. The sign reflected:- 2. The Administrator oversees the grievance procedure and coordinates the center system for collecting, tracking, and responding to grievances .- 9. The Administrator/designee routes the Grievance form to the appropriate department manager, who reviews the grievance, responds within five business days, and returns the Grievance Form to the Administrator.- 10. The person with the grievance has the right to a written decision regarding his/her grievance.- 14. Grievance forms/investigations are maintained for a minimum of three years.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews and record review, the facility failed to ensure grievances either voiced or provided to the facility were followed up on and resolved, and this was a system failure, to include: not assisting with verbal grievances, not identifying concerns and resolving them, not notifying the party filing the grievance of the resolution, not documenting steps taken to resolve the grievance, and not maintaining the grievance for 3 years from the date the grievance decision was issued for 1 (#21) of 34 sampled residents. This deficient practice affected all residents with grievances related to concerns or quality-of-care issues, which could negatively affect many or all of the residents residing at the facility. Findings include:During an interview on 1/26/26 at 4:41 p.m., resident #21 stated she had filed several complaints over the past couple of months. Resident #21 stated she filed grievances regarding the staff behavior, positioning during incontinence care, and dietary concerns. Resident #21 also stated she reported grievances for bringing resident #7 to the dining room without toileting her first because she had urinated in her chair several times a week. Resident #21 stated she had only received a response to one grievance. Resident #21 stated she complained regularly to the staff nurses and CNAs about the pain caused by the night shift CNA's incontinence care. Resident #21 stated she did not attend resident council because nothing gets done when residents complain. Resident #21 stated she was very loud and demanding to get her needs met, as it seemed the only way to get a response, but she worried about resident #7 who could not really speak up and get attention when needed.During an interview on 1/28/26 at 1:00 p.m., staff member A stated the grievance forms were missing from 10/7/25 through 1/25/26. Staff member A stated NF4 was responsible for the grievances and no longer worked at the facility. Staff member A stated the day after she left, everything was gone (documents). Staff member A stated NF4 would collect the grievances from the grievance box and would bring the grievances to her immediately for review. Staff member A stated she did not know why the 21 grievances completed by residents between 6/12/25 and 10/7/25 had not been investigated, resolved with the resident involved, and signed off by her. During an interview on 1/28/26 at 2:37 p.m., NF4 stated she did not know where the grievances were. NF4 stated she received an average of three grievances a week and turned them into staff member A. NF4 stated she was not in charge of collecting the grievances from the grievance box and did not know how many would be in the grievance box a week. NF4 stated the three grievances she received a week was in addition to those in the grievance box. NF4 stated she received and turned in at least 15 grievances from 11/1/25 to 12/31/25. Review of the facility's Grievance Forms received, dated 6/12/25 - 1/26/26, reflected:- No grievance forms from 10/8/25 through 1/26/26, and- 21 of 39 Grievance forms received contained complaints from residents, but no investigation, resolution, or person notified of resolution.Review of Center Grievance Official sign posted, updated March 2025, reflected Staff member A was the grievance Official. The sign reflected:- 2. The Administrator oversees the grievance procedure and coordinates the center system for collecting, tracking, and responding to grievances.,- . 9. The Administrator/designee routes the Grievance form to the appropriate department manager, who reviews the grievance, responds within five business days, and returns the Grievance Form to the Administrator., - . 10. The person with the grievance has the right to a written decision regarding his/her grievance., and - . 14. Grievance forms/investigations are maintained for a minimum of three years.

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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 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, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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	275111	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Health & Rehabilitation Center	820 3rd Ave Laurel, MT 59044

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 observations, interviews, and record review, the facility failed to report allegations of neglect and abuse to the State Survey Agency for 3 (#s 7, 18, and 21) of 34 sampled residents. This deficient practice resulted in resident #7 having fear of going to her room, resident #21 had fear of having her head hit the wall during care sessions, and for resident #21 voiced fear of having her head hit the wall during care (recurrent), and neglect of care related to care and services not being provided as needed for #s 7, 18, and 21. Refer to F600 for more information on failure to prevent abuse/neglect. Findings include:1. During an observation and interview on 1/26/26 at 4:20 p.m., resident #7 was crying while telling staff member J, who was pushing her in her wheelchair to her room, Please don't make me go in my room, I'm scared to go in there, please don't take me in there. Resident #7 stated, I dread going in there, my roommate wants everything her way . It's depressing to me . Staff leave me in there. Resident #7 stated she reported her concerns to the CNAs and nurses, but nothing was done about it. Due to the lack of response by the facility on her concerns, resident #7 continued to have ongoing fear and psychosocial harm. 2. During an interview on 1/26/26 at 4:41 p.m., resident #21 stated she reported the hitting of her head on the wall (she required a two-person assist), the CNA yelling at her, and placing a pad in her brief to the nurse and CNAs the morning of 1/26/26. 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 the night of 1/25/26, the CNA answered her call light and said she would come back but neglected to return until resident #21 had wet herself and her bed. Resident #21 stated the CNA came in and yelled at her, 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. Review of resident #21's MDS, dated [DATE], reflected resident #21 was on an antibiotic for a 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 neglect concerns, including staff not changing her or not using two people to change her brief, causing her pain, staff hitting her head on the wall during care, staff putting pads in her brief, dietary complaints, and call light times. Staff member M stated she reported resident #21's concerns to the nurse on duty when she heard of them. Staff member M did not report the concerns of abuse or neglect to the Administrator. It was found the care concerns voiced by resident #21 were not reported or addressed by the facility as abuse or neglect of care. 3. During an interview on 1/28/26 at 2:04 p.m., staff member M stated she arrived on shift on 1/26/26, and when she went to resident #18's room around 9:00 a.m., and she found him diagonally in his bed, and his feet were dangling off the bed. Staff member M stated resident #18 was urine-soaked from his shoes to his shoulders, his bed was urine-soaked, and urine was pooling in the bed. Staff member M stated resident #18 was still dressed in the same clothing from the day before. Staff member M stated that the staff tried to get him up at 8:30 a.m., that day, but he refused, so they left him there in that condition. Staff member M stated resident #18 did not have a history of soaking his bed with urine. Staff member M stated it appeared resident #18 was left unattended all night, and the next morning, without care. Staff member M stated she reported the neglect of care concerns to staff member L. The neglect was not reported to the Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 urine-soaked beds. Staff member N stated she reported the soaked beds to the nurse on duty when this occurred. During an interview on 1/28/26 at 2:20 p.m., staff member O stated she would commonly find residents would not have oral care done, there was poor peri care, and or staff member O would find urine-soaked resident 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 reported her concerns to her nurse. During an interview on 1/28/26 at 9:57 a.m., with staff member A and B, staff member 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 walls, or a CNA yelling at her, and were not aware of resident #7's fear of her roommate until the surveyor brought the concerns forward. Staff member A stated these concerns would qualify as allegations to be reported to the State Survey Agency for neglect and/or abuse. During an interview on 1/28/26 at 2:13 p.m., staff member M stated facility staff were given abuse education very frequently, but staff member M still did not know what specific instances the facility was required to report to the State Survey Agency or what they were required to report to administration. Staff member M stated they felt more education would be helpful specifically showing the line of what needed to be reported with examples and what did not need to be reported. Staff member M stated the line for knowing what to report or not to report was not clearly defined in the facility. Review of Facility reported incidents, from 1/7/25 through 1/25/26, reflected no reports for residents #s 7, 18, and 21's allegations and or the neglect of care concerns noted above. 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]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper ADL (Activities of Daily Living) cares were completed, specifically for 1 (#28) who was not receiving toenail care while her roommate #5 received toenail care biweekly; and for 3 (#s 11, 59, and 77) were not receiving showers from the facility. This deficient practice resulted in a resident feeling unclean and unkept. Findings include: 1. During an observation and interview on 1/26/26 at 4:07 p.m., resident #28 stated she only had her toenails clipped once in the time that she had been in the facility. Resident #28's feet were notably odorous from a distance once her socks and shoes were removed. She stated she had been at the facility for about three months. Resident #28's roommate (resident #5) stated she had her toenails clipped twice a week during her showers. During an interview on 1/28/26 at 1:47 p.m., staff member S stated resident #28 should have her toenails clipped biweekly or at least weekly by a nurse as resident #28 was a diabetic. Staff member S stated they usually had a reminder on the TAR reminding staff to complete this task, but there was no order present for resident #28. Staff member S stated this was the nurses' responsibility to complete and to call the physician for an order. Staff member S stated the wound care nurse, or the admitting nurse could have also put an order in so that it was not forgotten. Review of resident #28's EHR showed an admission date of 11/3/25. During an interview on 1/29/2026 at 2:05 p.m., staff member P stated the facility did not have an ADL policy. 2. During an interview on 1/28/2026 at 1:40 p.m., resident #11 and NF7 stated the facility was not giving the weekly baths that were promised to resident #11 and resident #59. NF7 and resident #11 stated the only showers they would receive were from hospice, when they came in once a week. Review of a facility document showing: Shower Days, not dated, showed showers were given to the Lilac hallway on Wednesdays and Saturdays. Both residents #11 and #59 were located in the Lilac hallway. Review of resident #11's EHR showed two documented bed baths in the past 30 days (on 12/31/25 and 1/27/26). Review of resident #59's EHR showed three documented bed baths in the past 30 days (1/7/26, 1/14/26, and 1/21/26). Review of resident #59's hospice Patient Communication Log showed showers were given on 1/7/26, 1/14/26 and 1/21/26. During an interview on 1/28/26 at 4:22 p.m., staff member T stated they were unaware of any complaints from residents regarding showers. Staff member T stated if a shower was not done that day, they would text the oncoming staff member to remind them to complete this task. Staff member T stated a shower sheet was completed after a shower and then this was given to a nurse so that this could be documented in the EHR. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/26 at 2:15 p.m., staff member A stated hospice came in once a week for resident #11. Review of a facility document, no title or date, showed: No specific policy on showers. Residents are asked preferences/choices and center attempts to meet them . 4. During an interview on 1/29/26 at 11:30 a.m., NF5 stated resident #77 was admitted to the facility on [DATE] for end-of-life care. NF5 stated she visited resident #77 on 12/9/25, six days after he was admitted to the facility. NF5 stated resident #77 voiced concerns regarding not having his teeth brushed or taking a shower since his arrival at the facility. NF5 stated resident #77's toothbrush was still sealed in the original package, indicating the toothbrush had not been used. NF5 stated she provided resident #77's oral care during her visit. NF5 stated a hospice aide was sent to the facility the following day to provide resident #77 a bed bath. During an interview on 1/29/26 at 2:10 p.m., staff member H stated if a resident was receiving hospice service, the hospice aide would be responsible for providing the resident with their scheduled shower or bath during their stay at the facility. Staff member H stated the facility could also provide the service, but the resident would need to ask. A review of resident #77's comprehensive care plan dated 12/3/25, showed: Problem: I have an ADL self-care performance deficit I have forgetfulness, weakness, adult failure to thrive . Interventions/Tasks: . BATHING/SHOWERING PREFERENCES: . FREQUENCY: 2 times per week . BATHING/SHOWERING: Dependent assist of staff with bathing. ORAL HYGIENE: Substantial/Maximal Assist . [sic] A review of resident #77's shower log showed the resident received a shower on 12/10/25, 12/17/25, and 12/24/25. On 1/28/26 a request was made for a facility shower policy. No documentation was received from the facility by the end of the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interview and record review, the facility failed to exercise reasonable care for the protection of a resident's property from loss or theft for 1 (#6) of 34 sampled residents. This deficient practice placed resident #6 at risk for continued loss of personal property and lack of resolution for reported concerns. Findings include: During an interview on 1/29/26 at 9:03 a.m., resident #6 stated that approximately six months earlier two shirts were taken from her clothes closet and five additional shirts were never returned from the facility's laundry service. Resident #6 stated she reported the missing items to facility staff. Resident #6 stated housekeeping searched for the items for a short period but did not locate any of the missing clothing. Resident #6 stated no facility staff have followed up with her since the report of missing items. During an interview on 1/29/26 at 11:00 a.m., staff member A stated if a resident's personal belongings were lost or stolen at the facility, she would expect the facility to replace the items. Staff member A stated resident #6's lost or stolen items should have been reported by staff using a grievance form and submitted to management. Staff member A stated she did not know why the required forms were not completed by facility staff. Review of the facility grievance forms dated 6/5/25 through 1/25/26, failed to show a grievance form was completed for resident #6's lost or stolen property. Review of the facility document titled, NOTICE OF THEFT AND LOSS CONTROL POLICY, dated October 2017, showed: The center makes reasonable efforts to safeguard resident property and valuables in accordance with state and federal guidelines. Suspected theft or loss of resident property is timely and thoroughly investigated. The following policies apply to the theft and/or loss of resident property: . 1. Center staff are oriented to theft and loss investigative procedures upon hire and during regular inservice training. 2. Any staff member who receives a report of a missing item from a resident, resident's family, or person acting on behalf of the resident completes a Grievance Form and forwards it to the Social Services Department. 3. Upon receipt of the Grievance Form, the Social Services Department initiates an investigation and/or searches for the missing item. 4. Results of the investigation or search are documented on the Grievance Form and communicated to the individual who sustained the loss or his/her responsible party. [sic]

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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]

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit each resident to remain in the facility and not transfer or discharge the resident from the facility without written notice and a safe discharge plan for 1 (#72) of 3 discharged residents subsampled. Findings include:Review of resident #72's Clinical Census EHR, no date, reflected resident #72 admitted to the facility on [DATE] and discharged from the facility on 12/5/25.Review of resident #72's EHR Progress Notes, dated 11/29/25 - 12/10/25, reflected:-Resident #72 left the facility at 12:30 p.m. on 12/5/25. Resident #72 did not return by midnight. Resident #72 had left the facility with a friend.-Resident #72 called the facility at 1:40 a.m. and left a voicemail stating her car broke down on the way back from visiting her mother and would call again in the morning.-Resident #72's sister called the facility on 12/6/25 and stated resident #72 had car trouble and would not make it back to the facility today but would hopefully make it back by tomorrow.-On 12/7/25 at 10:00 a.m., resident #72's female friend called the facility and stated she was picking up resident #72 to bring her back to the facility and NF4 told resident #72's friend the resident could not return to the facility and would need to be taken to the emergency room for evaluation. NF4 stated resident #72 had been gone for three midnights and had been discharged from the facility. NF4 stated resident #72 would need to be seen in the emergency room and screened to determine whether the facility and provider would be willing to readmit her due to her noncompliance and elopement. -The care manager of [Hospital Name] reached out to the facility for information on resident #72's previous stay in long-term care, cognition and ADL needs.During an interview on 1/28/26 at 7:55 a.m., staff member A stated she was not aware NF4 told resident #72 and her family that she could not return and needed to go to the emergency room. Staff member A stated resident #72 had not been gone for three midnights and should have been allowed to return. Staff member A stated she could not find any documentation the case manager at [Hospital Name] received a response to the communication request for information on resident #72. Staff member A stated the discharge was not planned and no discharge documents were available. Staff member A stated resident #72 did sign out on the resident sign out log on the day she left and the facility was aware she had left to go downtown but became concerned when she did not return the evening of 12/5/25.Review of the facility admission Packet page 9, no date, reflected:-6.2 Termination by the Center. The Center may terminate this agreement and the Resident's stay by providing written notice to the Resident Group or a family member. The Center shall initiate the Resident's transfer or discharge through the Resident, the Resident Group, the Resident's Attending Physician, appropriate agencies, or other known responsible party .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Health & Rehabilitation Center	820 3rd Ave Laurel, MT 59044

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to notify the resident and or the resident's representative, in writing, of the reason for transfer when transferring a resident to the hospital, for 1 (#35) of 34 sampled residents. Findings include:During an interview on 1/26/26 at 4:15 p.m., NF2 stated resident #35 was transferred to the hospital for stroke-like symptoms on 8/26/25. NF2 stated she did not receive a written notice of transfer from the facility.During an interview on 1/29/26 at 2:56 p.m., staff member A stated the social services department would have been responsible for sending the written notice of transfer for resident #35's hospitalization on 8/26/25. Staff member A stated it appeared the letter was not sent because it was not documented in resident #35's electronic medical record.Review of resident #35's electronic medical record failed to include a transfer notice for resident #35's facility-initiated transfer on 8/26/25.On 1/28/26 a request was made for a copy of resident #35's transfer notification, for the 8/26/25 facility-initiated transfer. No additional documentation was received from the facility by the end of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure a resident's PTSD triggers were noted on the resident's Care Plan for 1 (#61) of 34 sampled residents. Findings include:During an interview on 1/26/26 at 3:35 p.m., resident #61 stated he did have PTSD from the Vietnam and Kuwait War. He stated he did have memories and flashbacks from both wars, and he felt he was triggered from loud noises at times or when a person walked behind him (including when he was seated at a restaurant with people moving behind him). He stated no staff members from the facility had asked him about his triggers, but he felt they were important for staff members to know.Review of resident #61's Care Plan, initiated 7/2/25, showed: behavioral monitoring due to resident #61's PTSD diagnosis, and a revision on 1/27/26 which showed PTSD from Vietnam War - If resident does not want to talk about the stress they're feeling, don't pressure resident, honor their request and notify nurse or social services to follow up for any ongoing support/needs resident may have. Resident #61's Care Plan did not address any triggers or interventions.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents with hearing and vision limitations were provided group and individual activities to meet their needs and preferences for 1 (#1) of 34 sampled residents. This deficient practice resulted in resident #1 self-isolating. Findings include:During an interview on 1/26/26 at 3:55 p.m., resident #1 was sitting in her room, in her wheelchair, approximately 1.5 ft away from her television. The volume on the television was turned up very high. The curtains were pulled closed, and the room was dark. Resident #1 stated she tried to participate in activities for a while, but she could not hear or see the activities to actively participate, so she stopped going to the activities. Resident #1 stated there were no activities for someone who is blind and deaf. Resident #1 stated she did not receive regular visits from anyone in activities, so she enjoyed her television to keep busy. Resident #1 had a pocket talker (handheld auditory amplifier) and used it during this conversation, resident #1 stated the pocket talker was not effective for group activities. Resident #1 stated she liked to socialize with others and loved to read before her vision declined. During an interview on 1/26/26 at 4:10 p.m., staff member C stated she visited resident #1 once every two weeks. Staff member C stated she attempted to engage resident #1 in group activities, but resident #1 did not participate in activities because she could not hear or see during the activities. Staff member C stated resident #1 liked to go out on the patio and socialize during the summer months. Staff member C stated she had not looked into books on tape, assistive devices, or alternative activities for residents who were hard of hearing and legally blind. Staff member C stated she had not considered an additional one-to-one activity for resident #1 due to staffing limitations. Review of resident #1's MDS, dated [DATE], reflected resident #1's hearing was, highly impaired absence of useful hearing, and vision was Impaired-sees large print, but not regular print in newspapers/books, and MDS reflected resident #1 was feeling down, depressed, or hopeless.Review of the facility's Notice of Program Accessibility, no date, located in the admission packet, page 38, reflected: - [Facility name] and all of its programs and activities are accessible to, and useable by, disabled persons, including persons who are deaf, hard of hearing, or blind, or who have other sensory impairments.- .A full range of assistive and communication aids provided to persons who are deaf, hard of hearing, blind, or who have other sensory impairments. There is no additional charge for such aids.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to offer and ensure hearing aids were properly working for 1 (#63) of 34 sampled residents. Findings include:During an observation and interview on 1/26/26 at 12:57 p.m., resident #63 was very hard of hearing and stated he wanted his hearing aids fixed. Resident #63 stated whenever he requested anything, the facility took a long time to get anything fixed. During a follow up interview (on 1/27/26 at 8:13 a.m.), resident #63 stated his hearing aids were broken, and the facility would not help him in getting to the VA to have them fixed. Resident #63 stated he was unable to converse with anyone, including any healthcare workers that worked with him or his physician. Resident #63 stated there was no social worker at the facility who was able to help with the process of getting to the VA.Review of resident #63's EHR showed resident #63 had an admission date to the facility of 8/29/25.During an interview on 1/28/26 8:59 a.m., with staff members A and B, staff member A stated they recently had their social services employee quit and all of the social services duties now fell on staff member A and staff member B. Staff member B stated they had been asking all residents about hearing, eye, and dental appointments during care conferences.Review of a facility policy titled, Social Services admission and History, dated 11/2016, showed: . Social Services/designee provides the following: . i. Referral and appointment information. Written in pen on the bottom of the page showed: Care Conference eval has area for requested referrals for mental health, podiatry, dental, hearing, vision.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure incontinent residents received treatment and services to prevent urinary tract infections, avoid skin breakdown, and maintain continence to the degree possible for 3 (#s 7, 18, and 21) of 34 sampled residents. This deficient practice may have contributed to resident #21 developing a urinary tract infection and resident #7 developing a red, inflamed rash in two areas above and below her pannus. Findings include: 1. 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 Escherichia Coli urinary tract infection because CNAs were not changing her during the night and cleaning her properly. Resident #21 stated the night CNA would answer her call light and say she would come back but never did, and she wet herself and her bed, on 1/25/26. Resident #21 stated the CNAs came in and yelled at her, 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 CNA yelling at her and placing a pad in her brief to the nurse and CNAs the morning of 1/26/26.During an observation and interview on 1/27/26 at 1:30 p.m., staff member K was assisting resident #21 off the toilet and cleaning her peri-area and anus. Staff member K entered and began cares without wearing appropriate PPE for Enhanced-Barrier Precautions. Staff member K put on gloves, and began cleaning resident #21's anus, using multiple wipes from behind the resident while she stood up. Staff member K did not clean resident #21's vaginal or front area. Staff member K pulled resident #21's brief and pants up and assisted her back to her wheelchair. Afterwards, staff member K was asked about the Enhanced-barrier Precautions sign on the room door. Staff member K stated, Hum, and shrugged his shoulders. When asked about cleaning resident #21's front peri-area, staff member K stated, Well she's big so I can't really reach through from the back, but I try a little. Review of resident #21's,Care Plan, revision date 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 cares 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 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 not changing her brief and staff putting pads in her brief. Staff member M stated she reported resident #21's concerns to the nurse on duty when she heard them. 2. During an interview on 1/28/26 at 2:04 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 resident #18 was still dressed in the same clothing from the day before. Staff member M stated resident #18 did not have a history of soaking his bed. Staff member M stated it appeared resident #18 was left unattended all night and the next morning without care. Review of resident #18's MDS, dated [DATE], reflected resident #18 had a BIMS (Brief Interview of Mental Status) of 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 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 check and changes.During an interview on 1/28/26 at 2:20 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m., staff member O stated she would commonly find 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.During an interview on 1/28/26 at 9:57 a.m., with staff members A and B both stated they were not aware of resident #18 being soaked with urine, and resident #21's concerns with toileting or pads in her briefs. According to a National Institutes of Health journal article, Dr. [NAME]'s research showed, . Hygiene risk factors that increase the likelihood of developing recurrent UTIs include: . Wiping and washing the vaginal area (incorrectly) from back to front or more than once. ([NAME] N., 2025).Review of the facility's, CNA Competency-Peri-Care, Female, updated May 2015, reflected: . 10. Separate the labia, clean the area using one downward stroke (front to back). Do not wipe the same area of the washcloth/wipe for more than one pass.14. Apply soap to newly mitted washcloth or wipe. Clean the rectal/peri-area from the vagina to the anus in one downward wipe.Request for a policy related to check and changes for incontinent residents was made on 1/29/26 at 11:49 a.m. Staff member P stated the facility did not have a policy specific to assisting residents with incontinence care. References:Recurrent Urinary Tract Infections. StatPearls (Internet). Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK557479/?utm_source=chatgpt.com

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to offer fluids and nutrition to a dependent resident for 1 (#59) of 34 sampled residents. Findings include:During an observation and interview on 1/26/26 at 4:49 p.m., NF7 stated resident #59 was not getting enough fluids or food throughout the day and was worried about resident #59. NF7 stated resident #59 did not void yesterday and when NF7 asked the staff about the frequency of her previous voids, the staff were unable to answer or would disappear and/or forget to come back with an answer. NF7 stated the staff members . don't come enough, resulting in resident #59 not eating or drinking enough. NF7 looked into resident #59's mouth and found a small amount of food sitting in between both bicuspids. NF7 was upset, removed the food and stated resident #59 did not even have the right type of diet for her current ability. NF7 stated the food should be cut up really small because resident #59 was having a hard time chewing lately. NF7 stated when she asked administration about her concerns, NF7 stated, . Stuff doesn't happen fast. NF7 stated resident #59 was only supposed to be at the facility for a short time and then was supposed to be walking and back home.During an observation on 1/27/26 at 7:58 a.m., resident #59 had a full cup of apple juice and a full cup of cranberry juice.During an observation on 1/27/26 at 8:35 a.m., resident #59's fluids were at the same level as before and her breakfast tray was delivered at her bedside table. No staff were present to feed resident #59.During an observation on 1/27/26 at 9:31 a.m., resident #59's fluids were at the same level as before.During an observation on 1/27/26 at 10:49 a.m., resident #59 had one drink out of the apple juice cup, but the cranberry juice had not been touched. Resident #59 now had a full cup of water in her room (measuring a little less than 600 cc of water).During an observation on 1/27/26 at 12:14 p.m., resident #59's fluids had not changed from (10:49 a.m). The water was still at a little less than 600 cc.During an observation and interview on 1/27/26 at 3:33 p.m., NF7 stated she brought applesauce, Jello, and ice cream that she was able to get resident #59 to eat. The apple juice had been drank, and half of the cranberry juice had been drank as well.During an interview on 1/29/2026 at 7:34 a.m., staff member U stated if a resident was completely dependent on staff for hydration and nutrition needs, it was up to the staff to ensure this happened. Staff member U stated they would have to communicate well with the CNA's. Staff member U stated, if the kitchen sets a plate down and walks away, It's my job to make sure that's done and that she's (resident #59's) eating. Staff member U stated resident #59 had her good and her bad days for eating. Staff member U stated resident #59 probably needed a supplement. Staff member U stated resident #59 ate and drank more than what staff had initially reported to them. Staff member U stated they often talked to resident #59 every time that they were in her room. Staff member U stated resident #59 now perked up when they were in her room. Staff member U stated resident #59 seemed to eat and drink more with staff member U, but staff member U stated, But I interact with her (resident #59). Staff member U also stated resident #59 was now on hospice, but there was no difference in treatment between a resident on hospice and a resident not on hospice. Staff member U stated all residents should get the same treatment (assisted with eating and drinking as needed).Review of resident #59's Minimum Data Set, dated [DATE], showed:- Dependent for oral hygiene and eating,- Holding food in mouth/cheeks or residual food in mouth after meals, with an answer yes.Review of resident #59's EHR showed a medical diagnosis of down syndrome.Review of resident #59's physician's order, dated 11/2/25 showed: Regular diet, Soft and Bite Sized texture, Thin Liquid consistency.Review of resident #59's EHR showed no physician order to feed resident #59, who was completely dependent on staff.Review of resident #59's Care Plan, revised on 12/7/25, showed:- Impaired psychosocial well-being as evidenced by behaviors . related to a diagnosis of: . anxiety . down syndrome . cognitive communication deficit . Interventions: Offer food/drink .,-Alteration in nutrition/hydration. Interventions: . Offer fluids between meals.-Resident #59's Care Plan failed to show the resident was completely dependent on staff, and required feeding and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hydration assistance during meals.During an interview on 1/28/26 at 1:47 p.m., staff member S stated it was the nurse's responsibility to order the correct diet to ensure a resident was not a choking risk.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure tube feed bags were changed every 24 hours for 1 (#11) of 2 sampled residents receiving tube feedings. Findings include: During an observation on 1/27/26 at 9:46 a.m., resident #11's continuous tube feed bag was dated 1/26/26 and did not have any staff initials on it.During an observation and interview on 1/28/26 at 8:12 a.m. and at 10:17 a.m., resident #11's continuous tube feed bag was dated 1/26/26. There was spilled tube feed formula on the outside of the tube feed bag, as well as a significant amount of tube feed formula spilled on the floor. Resident #11 stated she did not know if new tubing was used every day, but stated she had seen staff refill the same bag before.During an interview on 1/28/26 at 8:15 a.m., staff member L stated they changed the tube feed bag every 24 hours. Staff member L stated, That's what I have always done.During an interview on 1/29/2026 at 7:40 a.m., staff member U stated tube feed bags and tubing needed to be changed every 24 hours because of what staff member U had learned in nursing school. Staff member U stated they initialed, dated, and timed the bag. Staff member U stated it was important to time the bag because the other shift could inadvertently still use the bag when it was after the 24-hour expiration.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, the facility failed to ensure a resident with post-traumatic stress disorder received trauma-informed care, accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 (#61) of 34 sampled residents. Findings include:Review of resident #61's EHR showed a medical diagnosis of PTSD.During an interview on 1/26/26 at 3:35 p.m., resident #61 stated he did have PTSD from the Vietnam and Kuwait War. He stated he did have memories and flashbacks from both wars and he felt he was triggered by loud noises at times or when a person walked behind him (including when he was seated at a restaurant with people moving behind him). He stated no staff members from the facility had asked him about his triggers, but he felt knowing the triggers were important for staff members to know.Review of resident #61's Care Plan, initiated 7/2/25, showed: behavioral monitoring due to resident #61's PTSD diagnosis, and a revision made on 1/27/26 which showed PTSD from Vietnam War - If resident does not want to talk about the stress they're feeling, don't pressure resident . No other triggers or interventions were identified.Review of resident #61's Trauma Informed Care Assessment showed resident #61's PTSD was assessed, but all answers requiring an explanation showed: Vietnam War. There were no specifics to explain what caused or triggered instances of anxiety, worry, or flashbacks. There were also no interventions shown.Review of a facility policy, titled Trauma-informed Care, updated 7/2025 showed: . 3. Based on the evaluation results, the appropriate provider and interdisciplinary notifications are made to support the care of a resident . 4. The resident's care plan is updated to reflect goals and interventions to provide care for the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate was less than 5% during 2 (#s 25 and 74) of 26 observed medication administrations. There was an observed medication error rate of 7.41%. Findings include:1. During an observation and interview on 1/27/26 at 7:52 a.m., staff member S prepared morning medications for resident #74. Staff member S looked at the medication bottle, Nephro Vitamins. The contents listed on the back of the medication bottle were:-Vitamin C, 60 mg-Vitamin B-1, 1.5 mg-Vitamin B-2, 1.7 mg-Niacin, 20 mg-Vitamin B-6, 10 mg-Folate, (800 mcg folic acid)-Vitamin B-12, 6 mcg-Biotin, 300 mcg-Pantothenic acid, 10 mgStaff member S looked at the MAR, hesitated, and stated the medication on the back of the bottle and the MAR were different. The MAR showed: Nephro-Vite Oral Tablet 0.8 MG (B-Complex w/C & Folic Acid). Staff member S stated, That's a good question, when answering how much of the medication they were supposed to give based on the order in the MAR and all the doses listed on the back of the Nephro Vitamin bottle. After clarifying the concern with the Director of Nursing, staff member S stated the medication order was not clear and the medication should not be given.2. During an observation and interview on 1/28/26 at 8:17 a.m., staff member L prepared the medications (aspirin, Tylenol, losartan, omeprazole, Miralax, and Nutren 1.5 Enteral tube feed) for resident #25. Staff member L gave the following amounts of water in the G-tube without following the physician's orders:-10 cc water-3 cc water with a medication-12 cc water-12 cc with a medication. Staff member L stated, I think (there is) 5 cc's (in the syringe). Staff member L then changed their mind and stated there was 12 cc in the syringe after looking at the syringe at eye level. Staff member L stated, It's really hard to see it. There were no lights on in resident #25's room.-10 cc water-10 cc water with a medication-20 cc water-10 cc extra to help flush down last medication-10 cc water with a medication-15 cc water. Staff member L stated, I'd say it's about 15 cc's because it's between 10 and 20 cc's.-10 cc water-100 cc of free water flush. This was the amount left over after administering all of the medications.Review of resident #25's physician orders showed: Enteral Feeding: . Water Flush To Total 245 cc's . and Enteral Feed: Water flush 5-10 cc's H2O per tube between each medication.The maximum amount of water staff member L should have given between the medications was 110 cc, and the additional free water to be given was 245 cc. Staff member L gave 122 cc of water between the medications, and 100 cc of free water. The total amount staff member L should have given during the entire medication administration was 355 cc of water, while staff member L only gave 222 cc of water.During the interview on 1/28/26 at 8:17 a.m., staff member L stated resident #25 could have extra water in the G-tube because they were allowed to drink water orally. Staff member L stated the only negative side effect of giving too much water to resident #25 was if he was at risk of heart failure. Staff member L stated they did not consider any other issues with giving too much or too little water in the G-tube.Review of a facility document titled, Medication Administration, updated 6/2017, showed: . c. Right Dose . The nurse verifies the dose via the prescription label and strength on medication container.11. If an order is unclear or a medication does not match the MAR, the nurse calls the physician for clarification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275111	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Health & Rehabilitation Center	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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to ensure dental services were offered in a timely manner for 2 (#'s 4 and 57) of 34 sampled residents. The failure placed residents at elevated risk for oral pain, infection, impaired nutrition, and decline in oral health. Findings include: 1. During an observation and interview on 1/28/26 at 2:31 p.m., resident #4 stated he would like to go see a dentist if that option was available to him. He stated no one ever asked him since he had been at the facility. Resident #4 had broken, missing teeth, and blackened areas on his front teeth. Resident #4 stated he would avoid hard foods because they hurt when he tried to chew them. The surveyor requested information related to resident #4's dental appointments, referrals, notes, and information provided showed: Review of a facility document, not titled or dated, showed in pen: [Resident #4] . 1/29/26: Doesn't want dental appointment at this time. Review of resident #4's Care Conference, dated 1/4/26, showed: . Referrals or Recommendations for Mental Health, Podiatry, Dental, Hearing, Vision: requesting f/u for wound care . There was no mention of whether the facility asked about dental needs at the time of the care conference. During an interview on 1/29/26 at 10:45 a.m., resident #4 stated he would rather have upper and lower dentures that fit properly than his current teeth where many hurt. He stated he was worried about any money that would be needed in order to see a dentist. Resident #4 also stated he would be interested in the process of picking his own dentist because he had bad experiences in the past. He stated he was unsure of who was available to see him at this time but was requesting information. During an interview on 1/29/26 at 12:38 p.m., NF8 stated she felt resident #4 would benefit greatly from going to the dentist. NF8 stated she felt that resident #4 had bad experiences in the past which made him afraid of going to the dentist. NF8 stated she knew finances were a concern because she had been waiting to hear from the facility if resident #4 qualified for Medicaid as this would also help pay for his stay. NF8 stated she was present during the last care conference, and she stated the facility staff did not ask resident #4 about going to the dentist. 2. During an observation and interview on 1/27/26 at 2:20 p.m., resident #57 was lying on his bed. Resident #57 stated he had broken and missing teeth in the bottom of his mouth. During the interview, resident #57 moved his tongue from one side of his mouth to the other pressing on the inside of his cheek. Resident #57 stated it was difficult for him to eat certain foods. Resident #57 stated it had been some time since he had been to the dentist and stated he had told nursing staff several times, but nothing was done. During an interview on 1/29/26 at 9:04 a.m., staff member Q stated if a resident voiced a concern, it would be reported to the nurse on shift, and they would then report the issue to management. During an interview on 1/29/26 at 9:30 a.m., staff member B stated resident #57 had no dental appointments scheduled. Staff member B stated she had met with resident #57 this morning and a dental appointment would be scheduled today (1/29/26). A review of resident #57's care conference document, dated 1/8/26, showed: (continued on next page)

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	275111	A. Building B. Wing	01/29/2026

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Laurel Health & Rehabilitation Center	820 3rd Ave Laurel, MT 59044

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. D. Social Services . 3. Referrals or Recommendations for Mental Health, Podiatry, Dental, Hearing, Vision: None. [sic] A review of facility- provided handwritten document titled, [Resident #57] Dental Visits, not dated, showed resident #57's last dental appointment was 1/13/25. A review of resident #57's care plan entry dated 12/5/21, latest revision date 1/4/26, showed: Problem: I have poor dentition I have a history of having a tooth removed and a crown placed . Goal: I will be free of infection, pain or bleeding in the oral cavity by review date . Intervention: Coordinate arrangements for dental care, transportation as needed/as ordered . Monitor/document/report PRN any s/sx of of oral/dental problems needing attention: . Teeth missing, loose, broken, eroded, decayed. [sic] Review of a facility policy titled, Social Services admission and History, dated 11/2016, showed: . Social Services/designee provides the following: . i. Referral and appointment information. Written in pen on the bottom of the page showed: Care Conference eval has area for requested referrals for mental health, podiatry, dental, hearing, vision.

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to provide a resident preference for Jello to 1 (#11) of 34 sampled residents. Findings include:During an interview on 1/27/26 at 9:46 a.m., resident #11 stated the facility would often run out of Jello in the facility. She also stated she was able to have applesauce, pudding, and Jello in the hospital, but staff at the facility told her she was only able to have Jello at the facility. She stated, Jello was the most important thing. That's the only thing I can eat (besides resident #11's continuous tube feed). Resident #11 stated she had a tumor in her throat that would not allow her to swallow other foods. Resident #11 stated strawberry Jello was her favorite and the facility never had that flavor available to her. She stated if they had Jello, the flavor was always orange.During an interview on 1/28/26 at 2:38 p.m., staff member G stated the facility had at least four or five flavors of Jello (cherry, lime, orange, and strawberry). Staff member G stated the facility had to make it from scratch as it was less expensive than the individual cups. Staff member G stated they were unaware of any residents requesting Jello specifically because of their diet or their difficulty in swallowing.During an observation and interview on 1/28/26 at 4:22 p.m., in the nutrition room, the fridge did not have any Jello. There were three trays of pudding present. Staff member T stated sometimes there would be Jello in the nutrition room and sometimes not. Staff member T stated Jello was present in the nutrition room about 50% of the time.Review of resident #11's physician order showed: Regular diet Soft and Bite Sized texture, Thin Liquid consistency, may have ice chips/ and small bites as desired for comfort related to dysphagia .Review of a facility document, no title or date, showed: No specific policy on resident preferences. Preferences are either expressed by resident or their responsible party, or staff and addressed in care planning. [sic]