STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275126	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation	1301 E Broadway Missoula, MT 59802

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to protect a resident's right to be free from non-consensual sexual contact by a staff member and ensure the resident had necessary social services following the alleged event for sexual abuse, and the resident was bothered, embarrassed, and felt humiliated after the event, for 1 (#1) of 9 sampled residents. This deficient practice did not allow the resident the opportunity to heal from the alleged event, which still bothered him as of the survey, and he was reportedly self-isolating due to his fear. Findings include: Review of a facility-reported incident, dated 5/22/26, showed: Resident (resident #1) reported to Unit Manager at 1615 (4:15 p.m.) that while 2 CNAs were changing his brief earlier in the day, (staff member M), CNA inserted her finger in his rectum. ED interviewed him and he states (staff member M) was checking his buttocks for open areas and was spreading his anus and he felt her finger enter his rectum. He believes she inserted it up to the ?second knuckle'. [sic]Review of findings for this allegation, dated 5/29/26, showed: The investigation found that the allegations are unable to be verified. The witnessing CNA reports she was not in the room for all of the cares. The resident did not say anything at the time, but the witness reports that he was quiet. ED interviewed 5 other residents on the same hallway.During an observation and interview on 6/15/26 at 1:26 p.m., resident #1's door was shut to his room, and he was lying on his bed. Resident #1 stated staff member M stuck her finger in his rectum past the second knuckle and moved it around. Resident #1 demonstrated a circular motion with his hand. Resident #1 stated he reported the incident to the nurse and later reported it to the police. Resident #1 stated staff member J was in the room and may have witnessed the incident. Resident #1 stated that staff member M does not take care of him anymore. Resident #1 stated he has declined his baths because of the incident and is scared it will happen again. Resident #1 stated he requested that staff member M not care for him anymore. Resident #1 stated nobody from the facility had followed up with him or had provided him with an outcome of the investigation. Resident #1 stated that no staff members had followed up with him to see how he was doing after the incident.During an interview on 6/16/26 at 8:55 a.m., staff member M stated, I don't know what incident you are referring to. The facility did not tell me anything before putting me on suspension. They accused me of sexual abuse and wouldn't even let me know who the resident was. I was cleaning his (resident #1's) bottom, and I can't do that without another CNA in the room because of his size. I didn't do anything wrong.During an interview on 6/16/26 at 10:10 a.m., NF1 stated the facility did not alert her when the incident with resident #1 occurred. NF1 stated that resident #1 was lucid sometimes and was hard to understand at times. NF1 stated, He (resident #1) told me about the incident, but I didn't really follow what he was saying at the time. NF1 stated the facility didn't let her know until a couple of days later. NF1 stated, He (resident #1) was quite upset about it; He (resident #1) even wanted to be in a private area to tell me about the incident so no one would hear him because he was embarrassed. NF1 stated that resident #1 had never had issues with any of the staff before this incident. NF1 stated, I do think he is still concerned about it. I want to see things come to a just conclusion. It has been weeks without resolution.During an interview on 6/16/26 at 12:09 p.m., (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff member E stated she would usually follow up with residents after an abuse allegation had occurred. Staff member E stated she was not involved in this specific investigation, and she had not followed up with resident #1 to see how he was feeling after the incident.During an interview on 6/16/26 at 12:40 p.m., staff member A stated she was the one who investigated the incident with resident #1. Staff member A stated she talked to resident #1, suspended staff member M, interviewed other residents, obtained a written statement from the witness, filed the police report, and contacted the family. Staff member A stated, Staff member E is aware of the incident, but she probably hasn't followed up with the resident. Staff member A stated she would have to check the electronic medical record for any further information.During an interview on 6/16/26 at 12:55 p.m., staff member J stated, I am not sure exactly what happened to resident #1. I was assisting in cleaning him up after he had a bowel movement, and had to pop my head out the door to check on other call lights, and when I came back to assist with cleaning up, he (the resident) was very quiet, which is not like him. He is usually joking with us and talkative. I didn't see how she (staff member M) was wiping him, and I can't really see over him when we have him on his side. So, I didn't see anything if it happened.During an interview on 6/16/26 at 2:38 p.m., resident #1 stated, Nobody said anything when the incident happened, including the nurse when I reported it. I did not react when it happened because I was in shock that it even happened. She (staff member J) was in the room when it happened and didn't say anything either. I didn't know how to react; it was quite a surprise. I just want to put it in the back of my mind and forget about it. It was humiliating and made me feel really uncomfortable.During an interview on 6/16/26 at 3:27 p.m., staff member G stated, He (resident #1) has been more withdrawn lately and hasn't come out of his room as much after the incident happened.Review of resident #1's Quarterly MDS, dated [DATE], showed: Section B - Hearing, Speech, and Vision, B0600 - Speech Clarity, 0 - Clear speech - distinct intelligible words; B0700 - Makes Self Understood, 0 - Understood; B0800 - Ability To Understand Others, 0 - Understands - clear comprehension .Section C - Cognitive Patterns, C0500 - BIMS Summary Score, Add scores for questions C0200-C0400 and fill in the total score (00-15), 15.Section I - Active Diagnoses, I0020. Indicate the resident's primary medical condition category, 06. Progressive Neurological Conditions . I5300. Parkinson's Disease.Resident #1's Quarterly MDS showed he was able to understand, had clear speech, and had a BIMS of 15, showing he was able to speak his needs and concerns and was cognitively intact.Review of resident #1's clinical progress notes, dated 5/22/26, showed: UM was notified via floor RN that resident had had an issue with a CNA earlier today. UM went to visit with resident at 1615 (4:15 p.m.). Resident stated the 2 CNA's that were on his hall today by name and also stated he (resident #1) didn't like one of them and told the other (staff member J) that he didn't want her (staff member M) in his room. He doesn't think that was relayed as both CNA's attended to him at just before noon. Resident stated he had had a bowel movement and the CNA he didn't like stuck her finger in my butt about to the 2nd knuckle it felt like. When asked why he didn't say anything until now resident stated because it didn't bother me until I had thought about it and now it bothers me. Resident asked if he felt safe at this time and he stated that he does. ED notified and CNA has been pulled off the schedule until further notice. [sic]There were no other progress notes, assessments, or documentation about the incident in resident #1's chart. Review of a facility provided document titled Timeline, undated, showed: 5/22/26 - Staff member A spoke with the resident and removed the accused staff member from the schedule.5/23/26 - Abuse report filed. Staff member A spoke with staff member M and requested a written statement.5/25/26 - Staff discussion5/26/26 - Staff members A and B spoke with the witness, three other residents were interviewed, and staff member M was suspended.5/28/26 - Staff member A spoke with resident #1 about filing a police report, and a police report was filed.5/29/26 - Staff member A notified NF1 of the incident with resident #1. Findings submitted to the State Survey Agency showed the facility interviewed five other residents.Review of a facility document titled Abuse, Neglect and Exploitation with a review date of 1/9/26, showed: Policy: Each resident has the right to be free from abuse, including verbal, sexual, physical, and mental abuse, neglect, corporal (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	punishment, involuntary seclusion, misappropriation of property, exploitation, and any physical or chemical restraint not required to treat the resident's medical symptoms. This prohibition applies to everyone, including, but not limited to, facility staff (employees, consultants, contractors, volunteers, and other caregivers who provide care and services to residents on behalf of the facility), other resident staff of other agencies serving the residents, family members, legal guardians, friends, or other individuals.IV. Prevention of Abuse. The facility will utilize the following techniques for prevention of abuse. Recognizes signs of burnout, frustration, and stress in employees that may lead to abuse. Provide education on what constitutes abuse, neglect, exploitation of residents, and misappropriation of property. React to all allegations or questions from residents, family members, employees, or visitors.

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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 complete a thorough investigation for an allegation of sexual abuse by a staff member for 1 (#1) of 9 sampled residents. This caused the resident to be frustrated that there was no resolution to the investigation. Findings include:Review of a facility-reported incident, dated 5/22/26, showed: Resident #1 reported to a staff member an incident of alleged sexual abuse by a staff member.Review of the facility's findings for this allegation, dated 5/29/26, showed: The investigation found that the allegations are unable to be verified. The witnessing CNA reports she was not in the room for all of the cares. The resident did not say anything at the time, but the witness reports that he was quiet. ED interviewed 5 other residents on the same hallway.During an interview on 6/15/26 at 1:26 p.m., resident #1 stated he reported the incident to the nurse on duty and later filed a police report. Resident #1 stated no one from the facility had followed up with him about the investigation or how he was doing. During an interview on 6/16/26 at 12:26 p.m., staff member B stated abuse investigations were a team effort, with staff member A reporting them and doing most of the investigation. Staff member B stated their process for investigating allegations of abuse was to ask the resident to describe the incident, interview other staff members, choose a sample of residents to interview, and to focus on the area of concern. Staff member B stated for the incident involving resident #1, she assisted by interviewing staff member J with staff member A present. Staff member B stated that staff member A conducted the rest of the investigation. Staff member B stated the last abuse training was conducted in March 2026, and she thought resident #1's care plan was updated to include care in pairs after the incident.During an interview on 6/16/26 at 12:40 p.m., staff member A stated she was the person responsible for reporting and investigating allegations of abuse. Staff member A stated she performed the following when she conducted the investigation of staff member M and resident #1: talked to the resident directly, immediately suspended staff member M, talked to other residents, and obtained the witness statement. Staff member A stated she filed a police report and contacted the family. Staff member A stated she did not document the interviews she conducted with other residents or staff, and she did not have a copy of the police report. Staff member A stated it would depend on what the police reports showed whether they would allow staff member M to return to work or not. Staff member A stated staff member M refused to write a statement. Staff member A stated social services did not follow up with resident #1 after the incident, but was aware of the incident. Staff member A stated there was no further information to provide for this investigation. During an interview on 6/16/26 at 12:09 p.m., staff member E stated her role when there is an allegation of resident abuse was to assist with interviewing other residents and follow up with the resident affected for any psychosocial outcomes. Staff member E stated staff member A was mostly in charge of investigating abuse allegations, but the Director of Nursing and Social Services would assist as needed. Staff member E stated she never followed up with resident #1 after the sexual abuse allegation, and she was not involved with that investigation at all due to a police report being filed, and it was still under investigation. During an interview on 6/16/26 at 2:38 p.m., resident #1 stated, Staff member A talked to me initially to file a police report and only came back to talk to me to see if the police had called me; no one has talked to me about the incident or the status of the investigation.During an interview on 6/17/26 at 9:25 a.m., staff member A stated she typed up a timeline of events for surveyor review, and there was no other documentation of staff member M's suspension or notification to the family of the incident. Review of the facility's investigation file for the incident dated 5/22/26 failed to show what other residents were interviewed, the questions that were asked, all staff who were interviewed, the details found in those interviews, the dates the interviews were conducted, follow-up with the resident for psychosocial outcome, and interventions for the resident if necessary. The investigation file consisted of the bounds report, a witness statement, a summary of steps taken, and a summary of notification to the family/POA. Review of resident #1's comprehensive care plan with (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an initiation date of 1/3/25 failed to show it was updated to reflect care in pairs and failed to show it was updated with any new interventions after the incident on 5/22/26 related to the resident's mental health and well-being as related to his feelings and the incident. Review of a facility document titled Abuse, Neglect & Exploitation with a last reviewed date of 1/9/26 showed: Policy: Each resident has the right to be free from abuse, including verbal, sexual, physical and mental abuse. VIII. Investigation of Alleged Abuse, Neglect, Exploitation, and MisappropriationWhen suspicion of abuse, neglect, exploitation, or misappropriation or reports of abuse, . an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation shall be conducted. Components of an investigation shall include when appropriate:-Interview the involved resident, if possible, and document all responses. If residents cognitively impaired, interview the resident several times to compare responses. -Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area and visitors in the area. Obtain witness statements, according to appropriate policies. All statements should be signed and dated by the person making the statement.-Document the entire investigation chronologically.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide ADL care of bathing for dependent residents for 4 (#s 1, 3, 6, and 8) of 9 sampled residents. This caused resident #1 to feel unclean. Findings include: During an observation and interview on 6/15/26 at 1:29 p.m., resident #1 was lying in his bed, and his nails were long and had a brownish substance under them. Resident #1 had flakes of dry skin peeling off on his arms. Resident #1 stated, I need assistance with showers. I have a private room with a bathroom. I don't trust myself alone in there because the whole bathroom gets wet when I shower, and I might slip. I need assistance, and my showers are often missed. I feel dirty when I miss my showers.During an interview on 6/15/26 at 4:54 p.m., staff member G stated, Evening shift showers are probably the task that gets missed the most.During an interview on 6/17/26 at 7:16 a.m., staff member P stated the person working the hall is responsible for doing the daily scheduled baths. Staff member P stated, It's hard to complete showers when there is only one person on the hall; many of the staff don't feel comfortable leaving the hall long enough to complete a bath or shower when there is only one person working the hall.During an interview on 6/17/26 at 7:26 a.m., staff member L stated that whoever is working on a hall is responsible for doing baths and showers. Staff member L stated if a resident refuses to take a shower, they will offer them a bed bath, and that is documented in their medical record. Staff member L stated it can be difficult to get them all done when there is only one staff member working the hall. During an interview on 6/17/26 at 8:52 a.m., staff member B stated the unit manager scheduled the resident showers and tried to meet the residents' preferences. Staff member B stated that the unit manager spreads the showers out throughout the three shifts, so staff do not get overloaded. Staff member B stated that the staff who are working the hall are responsible for completing the showers on that hall. Staff member B stated the unit manager owns the process for bathing and is responsible for ensuring they (showers) are getting done. Staff member B stated that if they identify a resident who has continually refused showers, they will monitor and attempt to identify the reasoning for the refusals. Staff member B stated she needed to talk to the unit managers about their monitoring process for bathing to ensure they were identifying those residents who are not getting bathed/showered. During an interview on 6/17/26 at 12:50 p.m., staff member K stated that resident baths and showers are not consistently provided on Birch Hall because the staff did not feel comfortable leaving the hall for the amount of time it would take to complete a resident bath or shower.a. Review of resident #1's 30-day lookback for bathing showed: Bath Day Wednesday and Saturday Eve shift, two showers were completed in the 30-day lookback period of 5/23/26 - 6/13/26.Review of resident #1's care plan showed: Bathing: Bathing/Shower assistance requires physical help in part of bathing activity.b. Review of resident #3's 30-day lookback for bathing showed: Bath Days (Wed and Sunday - evening shift), two showers were completed in the 30-day lookback period of 5/24/26 -6/14/26.Review of resident #3's care plan showed: Bathing: Prefers to be showered once per week.Review of resident #6's 30-day lookback for bathing showed: Bath Day Thursday and Sunday Eve shift: No showers were completed in the 30-day lookback of 5/21/26 - 6/14/26.c. Review of resident #6's care plan showed: Bathing: Bathing/Shower assistance requires total assist from staff.d. Review of resident #8's 30-day lookback for bathing showed: Bath Day Thursday and Sunday Day shift: No showers were completed in the 30-day lookback of 5/21/26 - 6/7/26Review of resident #8's care plan showed: Bathing: Bathing/Shower assistance requires physical help in part of bathing activity.Review of a facility document titled Activities of Daily Living, with a reviewed date of 10/27/25, showed: Policy:The facility ensures that the resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.Definitions: Activities of Daily Living include the resident's ability to:1. Bathe. Procedure: .3. Provide necessary services for residents who are unable to carry out activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide sufficient staffing, which contributed to ADLs not being completed for dependent residents for 4 (#s 1, 3, 6, and 8), low staffing concerns reported by residents for 4 (#s 1, 4, 5, and 9) of 9 sampled residents; and multiple staff concerns of not having enough time to complete assigned tasks or take their breaks. Findings include:During an interview on 6/15/26 at 1:26 p.m., resident #1 stated, I have a private bathroom, and I think they assume I can just walk in there and take my own shower. I need assistance, and my showers are often missed.During an interview on 6/15/26 at 4:54 p.m., staff member G stated, Evening shift showers are probably the task that gets missed the most.During an interview on 6/17/26 at 7:16 a.m., staff member P stated the person working the hall is responsible for doing the daily scheduled baths. Staff member P stated, It's hard when there is only one person on the hall; many of the staff don't feel comfortable leaving the hall long enough to complete a bath or shower.During an interview on 6/17/26 at 12:50 p.m., staff member K stated, Baths and showers are not consistent on Birch Hall because the staff does not feel comfortable leaving the hall for the amount of time it takes to complete a bath or shower.Review of resident #1's 30-day lookback for bathing showed three missed showers.Review of resident #3's 30-day lookback for bathing showed four missed showers.Review of resident #5's 30-day lookback for bathing showed two missed showers.Review of resident #6's 30-day lookback for bathing showed six missed showers.Review of resident #8's 30-day lookback for bathing showed six missed showers.2. During an interview on 6/15/26 at 1:26 p.m., resident #1 stated, There is not enough staff to meet our needs, and sometimes things like bathing get missed. I think the problem (low staffing/lack of care) is keeping quality people here.During an interview on 6/15/26 at 3:09 p.m., resident #4 stated, It seems like they are always short-staffed, and when they are short-staffed on other halls, they always pull the staff from this hall, and baths get missed. During an interview on 6/15/26 at 3:12 p.m., resident #5 stated, It seems like most of the time they are short-staffed. That is what we hear, and you can tell when there isn't enough staff. Our baths get missed.During an interview on 6/15/26 at 3:20 p.m., resident #9 stated, I don't feel like there is enough staff here. I know they could use more. During an interview on 6/15/26 at 4:02 p.m., staff member H stated CNA shifts are eight-hour shifts, but due to staff turnover, some have been working 12-16-hour shifts. Staff member H stated, You never know how many staff you are going to have on the evening shift. I think it is supposed to be two, but that rarely happens on Cedar Hall. During an interview on 6/15/26 at 4:17 p.m., staff member N stated tasks often get missed on the evening shift on Cedar Hall due to only one staff member being on shift. During an interview on 6/15/26 at 4:54 p.m., staff member G stated, I think I have taken one break the whole time I have worked here. Only one person is scheduled during the evening shift on Birch Hall, and it is hard to find the time to take them (breaks) and still meet the demands of the residents.During an interview on 6/17/26 at 7:16 a.m., staff member P stated the facility tried to get away with only one staff member on the Birch Hall when the census was low. Staff member P stated the capacity of Birch Hall is 14, and the hall currently had 13 residents. Staff member P stated staff missed their breaks all the time when there was only one person scheduled. Staff member P stated, I try to assist where I can. During an interview on 6/17/26 at 12:50 p.m., staff member K stated, There is usually only one person scheduled on Birch Hall during the day, but it depends because they (management) always pull staff from Birch Hall to assist with appointments. Staff member K stated there was always one person scheduled on Birch Hall for evenings and nights. Staff member K stated, Management is pushing for us to take our breaks, but there aren't enough staff to do so. Staff member K stated there were three residents on Birch Hall who were a two-person transfer, and it was hard to get extra help during the busy times, such as around mealtimes.Review of the facility's CNA schedule for the Birch Hall for the dates of 6/1/26 - 6/14/26, showed:Day shift: 6:00 a.m. to 2:30 p.m., 7 out of 14 days, one CNA (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	scheduled.Evening shift: 2:00 p.m. to 10:30 p.m., 12 out of 14 days, one CNA scheduled.Night shift: 10:00 p.m. to 6:30 a.m., 14 out of 14 days, one CNA scheduled.Review of a facility document titled Part 4: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, undated, showed: .Staffing Plan: Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. The facility fills a complete schedule weeks in advance, taking into account resident census and needs. Nursing manager/ED review the schedule to confirm appropriate. This review includes weekends, evenings, and holidays. Position: Nurse aides, 142-145 hr/day.