STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275135	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Discovery Care Centre Ltd	601 N 10th St Hamilton, MT 59840

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 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 on an event of staff to resident abuse by failing to complete resident monitoring, failed to carry out interventions identified and documented on the report, and failed to complete other resident interviews to rule out other concerns of abuse by the staff member, for 1 (#2) of 6 sampled residents. Findings include:Review of the facility reported incident investigation, completed by the facility on 6/26/25, showed NF4 was witnessed by several management staff verbally abusing resident #2. NF4 was immediately walked out and released from the position at the facility. The facility reported incident documentation showed, .Resident [#2] placed on every-shift monitoring x72 hours One-on-one [sic] emotional support provided. No other resident interviews or assessments were conducted during the investigation to rule out other concerns of abuse by the staff member. During an interview on 8/26/25 at 11:57 a.m., staff member A stated he was not in the office when the former DON handled the incident for resident #2 and NF4 and was unaware of other resident interviews. Staff member A stated that everything for the investigation was in the file provided.During an interview on 8/27/25 at 12:29 p.m., staff member C stated when a resident was put on alert charting or monitoring, it would be placed on the resident's MAR and TAR for the floor nurses to document and enter the monitoring progress notes.Review of resident #2's nursing progress notes and the MAR and TAR, for the 72 hours following the event, showed the only progress note was on 6/28/25 at 10:33 p.m., two days after the incident. The note was categorized as a behavior note and it included Resident appears somnolent tonight 6/28. Resident refusing some cares which is out of character for her. No interventions were noted for resident #2's change in behavior. There was no other documentation of the incident, one on one support, or the 72 hour monitoring in the progress notes. Review of resident #2's June 2025 MAR and TAR failed to include every shift monitoring for 72 hours.Review of the facility policy, Abuse, Neglect, and Exploitation, dated 4/11/25, showed: .Possible indicators of abuse include, but are not limited to: .Verbal abuse of a resident overheard. Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame.identifying and interviewing all involved persons, including.others who might have knowledge of the allegations.determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause.F. Providing emotional support and counseling to the resident during and after the investigation.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0627 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the required discharge process to include obtaining physician orders to discharge the resident from the facility; failed to obtain physician orders to setup up home health post discharge as care planned; and failed to document discharge planning communication, and the day of discharge process, including when, where to, what the discharge orders for care were for 1 (#1) of 6 sampled residents. This failure led to the resident not having proper support in place at the discharge location, and subsequently, the resident returned to the hospital for continued care. Findings include: During an interview on 8/26/25 at 11:20 a.m., NF1 stated, she was just made aware of a resident being in the hospital that had discharged from the facility in the beginning of August. NF1 stated the facility never notified her of the discharge and in talking with representatives of [resident #1], he had ended up having to go to the ER and then transferred hospitals for surgery for an infection. NF1 stated she was told he now had been placed on hospice at the hospital. NF1 stated there were other issues mentioned by the representatives. During an interview on 8/26/25 at 4:48 p.m., NF2 stated she was working with the family of resident #1 for support in the community for housing. NF2 stated the only notice they were given for resident #1 discharging was when the notice of non-coverage from his insurance was issued on 8/6/25. NF2 stated the facility did not communicate with her or the family on the discharge at all during his stay at the facility or his condition level and they were not able to ensure the home was safely set up for his return. NF2 stated it took three people to get resident #1 into the home the day of discharge because he could not ambulate. NF2 stated they were under the impression resident #1 was to have home health ordered to continue care and therapy when he was discharged ; however, it was not set up by the facility. NF2 stated resident #1 was not able to be safe at home and subsequently had ER visits with an admission to a local hospital. NF2 stated the hospital placed resident #1 in the intensive care unit after surgery for an infection. NF2 stated the family of resident #1 elected to place him on hospice. During an interview on 8/27/25 at 12:23 p.m., staff member C stated she was the nurse working when resident #1 discharged from the facility. Staff member C stated she did not document a progress note or discharge note in resident #1's medical record. The only documentation was the discharge form the resident signed when leaving, acknowledging the nurse reviewed medications and treatments, and any follow-up care after discharge. Staff member C stated she was unaware of any discharge planning communication or meeting with resident #1, and his family before discharge. Staff member C stated she just discharged him because it was on her assignment for the shift. Staff member C stated resident #1 went home in the mid-morning with a family friend on 8/8/25, and it took two facility CNAs assisting the resident's friend to transfer resident #1 into the vehicle. Staff member C stated she did not believe the facility had social services or a DON at the time who would have done the discharge summary documentation.During an interview and observation on 8/27/25 at 2:18 p.m., staff member D stated she would not normally document in her notes the family was visiting or discussions about insurance not covering the resident's stay if the resident did not participate in therapy. Staff member D showed her records of missed therapy visits and pulled up multiple missed ones for resident #1 being unavailable or his refusals due to visitors being present, him not wanting to get up, or pain (which was being managed and adjusted). Staff member D stated resident #1 was not participating in therapy and had declined prior to the discharge from the facility from his prior functioning level on admission. Staff member D stated resident #1's family support was limited as the spouse had her own health concerns. Staff member D stated she did not know of any documentation, communication, or care planning with resident #1 prior to his discharge.During an interview on 8/27/25 at 3:45 p.m., NF5 stated resident #1 was a very sick person and had multiple rehospitalizations prior to his stay at the facility. NF5 stated resident #1 had home health support services to help with wound care and comorbidity management before he stayed at the facility and would expect the facility to order this again on the resident's discharge. NF5 stated he could not find a discharge order for resident #1, but the practice was to get the physician's order near the day of, or on the day of, discharge, and this would include any other orders for home health. NF5 stated there was a chance another provider wrote the physician order, but he could not find it at the time. NF5 stated resident #1 would have preferred being home and was not the best at managing his health conditions. NF5 stated he was recently notified resident #1 was admitted to a local hospital and had written a physician's order to place resident #1 on hospice due to his decline and osteomyelitis During an interview on 8/26/25 at 4:32 p.m., staff member A stated the facility