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	11/18/2025

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 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. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record reviews, a staff member displayed verbally abusive behavior to residents residing in the secure unit. The facility identified the verbal abuse, reported it, investigated the event, and implemented corrections. This event was identified to be past non-compliance. Findings include:Review of a facility reported incident, submitted to the State Survey Agency, dated 8/29/25, showed, an unidentified staff member reported to staff member I, they overheard staff member J yelling at residents on the memory care unit. All residents residing in the memory care unit were identified to be vulnerable. During an interview on 9/25/25 at 10:49 a.m., staff member I stated that she is the one who completes abuse investigations. Staff member I said she was told about the incident with staff member J yelling at the residents, and she immediately reported it to the administrator, and an investigation was started. Review of the findings and documentation included in the investigation for staff member J yelling, which was submitted to the State Survey Agency on 9/8/25, and the information showed: - At approximately 2:26 p.m., a facility CNA reported, via text message to staff member I, that an employee (J) allegedly yelled at residents in the Memory Care Unit during the night shift. The allegation involved potential verbal abuse directed toward vulnerable residents. The initial report did not identify specific residents or the exact language used by staff member J. - The allegation was immediately reported to the administration. - All residents on the Memory Care Unit were assessed for signs of distress or changes in behavior. No acute distress was noted.- Observations of the residents residing in the Memory Care Unit were conducted to ensure their safety and well-being.- Staff member J was suspended following initial staff interviews to ensure resident protection.- A thorough investigation was conducted, which included staff interviews and observations. Interviews confirmed that staff member J had demonstrated negative verbal interactions with residents on prior occasions. The facility substantiated the allegation of verbal abuse. A review of the facility's investigation documents showed staff member J was suspended immediately while the abuse investigation was conducted, and residents were assessed for negative outcomes. The results of the investigation showed staff member J was subsequently released from the position at the facility. All staff were educated on resident rights, the facility's policy on zero tolerance for abuse and neglect, and mandatory requirements for reporting abuse and neglect. Ongoing monitoring of the Memory Care Unit was conducted through leadership rounds to identify concerns related to abuse or neglect. Additional in-service training sessions on abuse prevention and communication standards were completed with staff. The results of the investigation were reviewed in QAPI to ensure corrective measures were taken and corrections were sustained. Review of a facility document titled Abuse, Neglect and Exploitation, with an implementation date of 4/11/25, showed: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property.Policy Explanation and Compliance Guidelines:1. The facility will develop and implement written policies and procedures that:a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property;b. Establish policies and procedures to investigate any such allegations; andc. Include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention; andd. Establish coordination with the QAPI program. [sic]It was determined that the deficient practices related to the events in the secure unit with the vulnerable residents were corrected, therefore, the failure was cited as past noncompliance. The facility corrected the deficient practice(s) on 9/19/25.

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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 on a staff to resident verbal abuse and neglect allegation, 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 2 (#s 17 and 18) of 18 sampled residents. Findings include:Review of all facility reported incidents and facility investigations since August 27, 2025, showed there was insufficient documentation to show the facility completed thorough investigations on events reported to the State Survey Agency. The concerns included: -Incident #2609523 - There was no summary provided on the incident; there were no other residents and or staff interviews, and no corrective actions or interventions taken by the facility.-Incident #2609623 - The documents failed to include evidence on how the facility provided education to staff, and there were no bathing logs or audits conducted by the facility for monitoring and sustaining any corrections attempted. -Incident #2609701 - The documentation failed to show that the facility interviewed other residents and staff to identify others who may have been affected by the deficient practice.During an interview on 9/23/25 at 6:30 p.m., staff member C stated she had not reviewed the incident investigation folders yet and would look through them. During an interview on 9/24/25 at 7:20 a. m., staff member C stated she reviewed the incident and investigation folders, and staff member C identified that the investigations were not complete. Staff member C stated the facility was still working on them, as the events were part of the plan of correction from a prior complaint survey. Review of a facility document titled Abuse, Neglect and Exploitation with an implementation date of 4/11/25 showed: Policy: it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.VII. Reporting/Response A. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies.5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following:a. Analyzing the occurrence.b. Defining how care provision will be changed.c. Training of staff on changes made and demonstration of staff competency.d. Identification of staff responsible for implementation of corrective actions.e. The expected date for implementation.f. Identification of staff responsible for monitoring the implementation of the plan. [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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to provide regular showers for 10 (#s 6, 7, 11, 12, 13, 14, 15, 16, 17, and 18) of 18 sampled residents, and some of the residents felt dirty and or were upset by the failure. Findings include:1. During an observation and interview on 9/23/25 at 9:35 a.m., resident #12 was in her room; her hair appeared oily, and she looked unkempt. Resident #12 stated, A staff member refused to help me with my baths. I missed a few baths, and it made me feel dirty and stinky. I wish I could take a bath every day.Review of resident #12's last 30 days of the shower log showed the resident had a bath/shower given on 9/9/25, and then again on 9/17/25, with seven days between the bath/shower. The next bath/shower was performed on 9/22/25, four days later. Review of resident #12's care plan, with a revision date of 6/1/25, showed: Focus: Self care deficit: Requires assist with ADL's due to: decreased mobility secondary to disease process, required assistance with ADLs as noted on nursing admission evaluation.Interventions: .Bathing/Shower assistance requires supervision/cueing only. [sic]2. During an observation on 9/23/25 at 8:52 a.m., resident #14 was sitting in a wheelchair in her room. Her hair looked matted and messy. She looked unkempt.Review of resident #14's 30-day lookback shower log showed two baths were given in the 30-day lookback period of 8/25/25 to 9/22/25. There were only two baths/showers given, which were on 8/31/25 and 9/8/25. There were 14 days after the last bath/shower. Review of resident #14's care plan, with a revision date of 6/1/25, showed: Focus: Self care deficit: Requires assist with ADL's d/t memory deficits related to her diagnosis of Parkinson's.Interventions: [resident's name] requires extensive assist with showering. If she declines a shower offer a bed bath. Notify nurse if resident declines bed bath as well. [sic]3. Review of a questionnaire filled out by resident #17, on 8/31/25, showed a response to the question, Do you feel safe living here at the facility? The following was marked, No - I have felt neglected and ignored. I had two showers in a month.Review of resident #17's shower logs showed two baths were completed in the 30-day lookback period, which were on 8/26/25 and on 9/2/25.Review of resident #17's care plan, with a revision date of 9/6/25, showed: Focus: [resident name] has self care deficit: requires assist with ADL's due to left knee instability, weakness, dyspnea.Interventions: Bathing/Shower assistance requires physical help in part of bathing activity. [sic]4. During an observation on 9/23/25 at 8:54 a.m., resident #11 was sleeping in her wheelchair, bent forward. Her hair was matted and uncombed.During an observation and interview on 9/23/25 at 11:22 a.m., resident #11 was sitting in a wheelchair in her room; her hair was matted and messy. Resident #11 was having difficulty answering questions, but did say no when asked if she was receiving baths regularly.Review of resident #11's shower logs showed only two baths were conducted in a 30-day lookback period. Baths were done on 9/3/25 and 9/19/25. There were 16 days in between the two baths. Review of resident #11's care plan with a revision date of 9/28/22 showed: .Focus: ADLs: [Resident Name] requires fluctuating assistance with ADLs due to decreased mobility, weakness, unsteady gait/balance, and history of falls.Interventions: Bathing: [resident name] needs extensive staff assist with bathing. Allow [resident name] to assist in the bathing process as much as she is able. If she declines to bathe please re approach her at a later time. [sic]5. Review of a facility reported incident, dated 9/3/25, showed that resident #18's family had contacted the facility and expressed a concern about her mother's hair being matted and uncombed. She further expressed concern with the number of baths her mother was receiving.Review of resident #18's shower logs showed two baths were provided in a 30-day lookback period. Baths were done on 8/31/25 and 9/10/25. Review of resident #18's care plan with a revision date of 6/1/25 showed: .Focus: ADLs/Communication: [Resident name] needs assistance with her ADL's related to history of left sided ischemic stroke with right side hemiparesis. She has expressive and receptive aphasia, and history of convulsions. She is not able to use her right arm.Interventions: [resident name] needs extensive assistance of one person for bathing. She chooses to shower once a week. She prefers showers when she bathes. [sic]6. During an observation and interview on 9/23/25 at 9:47 a.m., resident #16 was in his room, sitting in his recliner. His hair appeared oily, his whiskers were long, and he had drool and dried food on his shirt. When asked if he received regular showers, he stated, I had one last week, but not yet this week.Review of resident #16's shower logs showed five baths were provided in a 30-day look back, which were on 8/25/25, 8/31/25, 9/10/25, 9/14/25, and 9/17/25. There was a period of nine days between the 8/31/25 and 9/10/25 bathing sessions. Review of resident #16's care plan with a revision date of 6/1/25 showed: .Focus: ADLs/Communication: [resident name] requires assistance with ADLs due to decreased mobility and weakness related to a diagnosis of Parkinson's disease.Interventions: Bathing: [resident name]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, interviews, and record reviews, the facility failed to provide sufficient staff for the Memory Care Unit residents, to ensure monitoring and assistance with safety, provision of ADL care, meal assistance, and abuse prevention for 6 (#s 1, 2, 5, 8, 9, and 10); and failed to ensure staff were available to assist with resident bathing/showering, as needed, for 10 (#s 6, 7, 11, 12, 13, 14, 15, 16, 17, and 18) of 18 sampled residents. The failure to provide ADL bathing/shower assistance made some residents feel dirty, and they appeared unkempt or neglected. Findings include: During an interview on 9/23/25 at 8:50 a.m., staff member F stated there was not enough supervision on the memory care unit when resident #1 was going at it because she was a one-to-one. Staff member F stated that resident #1 was very disruptive and loud. Staff member F further stated that resident #1 was difficult to redirect; she banged on things, wandered, and targeted other residents. Staff member F stated the facility was having staffing issues. When asked about the frequency of support from the activity staff, staff member F said activities on the memory care unit just started this week.During an observation on the memory care unit, on 9/23/25 at 8:55 a.m., resident #2 was observed in blue pajamas with pink hearts. Resident #9 was observed in sweatpants and a button-up shirt that was misbuttoned over her night gown.During an interview on 9/23/25 at 11:10 a.m., staff member E stated, It is sometimes hard to complete all my tasks. I usually stay late to chart and skip doing baths just to get through the demands of the shift.A review of bathing records for 30 days for resident #s 6, 7, 11, 12, 13, 14, 15, 16, 17, and 18 showed baths or showers were not provided as scheduled or needed for the residents reviewed. Observations, interviews, and record reviews supported the lack of bathing services. Refer to F677 ADL Care, for individualized information related to the provision of ADL assistance with bathing/showers. During an observation on 9/23/25 at 5:45 p.m. to 6:10 p.m., the following was observed on the memory care unit:Resident #2 was seated at a dining table observed in the same set of blue pajamas with pink hearts as earlier in the day. Resident #2 got up from her seat, left her walker at the dining table and walked unassisted down the hall. Resident #5 followed resident #2 with her walker. There was no staff member in the area to assist.Resident #1 was seated in a recliner in the common area and was yelling, help! and she stated she was scared. Resident #8 then asked resident #1 to be quiet and told her to shut up. Staff member F had stated that prior resident #1 was a one-to-one supervision, but there was no staff member in the area to intervene.During an interview on 9/23/25 at 6:25 p.m., staff member F stated, I don't think there is enough staff in the memory care unit. Staff member F stated there were residents with lots of behaviors, and only one nurse and one aide. There was never time to do the baths, and staff member F stated, I would say bathing is the number one task that gets missed when short-staffed. We just don't have time to do them. During an interview on 9/24/25 at 9:32 a.m., staff member K stated, I do think there is an issue with being understaffed. I know it affects bathing. The staff don't have enough time to do baths, along with the rest of their tasks. The facility used to employ a bath aide, and that helped a lot.During an interview on 9/24/25 at 9:41 a.m., staff member H stated it was difficult to get to the Memory Care Unit since she took over the department in June. Staff member H stated she has not been able to do it (work on the memory care unit) at all. Staff member H stated that transport comes first before activities. Staff member H stated she had asked time and again to get help, and it hasn't happened. Staff member H stated she does not feel like there is enough staff on the Memory Care Unit to ensure the protection of the residents.During an observation on 9/24/25 at 11:38 a.m., resident #9 was observed wearing sweatpants and a button-up shirt that was misbuttoned over her nightgown, which was the same clothing she wore the day prior. Resident #2 was observed in blue pajamas with pink hearts, the same clothing she wore the day before. During an interview on 9/24/25 at 11:54 a.m., staff member H stated she was the only certified staff member on the memory care unit, providing ADL care, and it was rare that another person (certified) was scheduled to work the unit also. During an observation on 9/24/25 at 12:06 p.m., resident #10 was eating her lunch with her fingers and was not assisted by staff. Resident #10 poured her water onto her lunch plate. Staff present in the dining room did not intervene or assist resident #10 with her meal.During an interview on 9/24/25 at 12:22 p.m., staff member C said she thought the facility was going in the right direction for staffing (improving), and they have identified staffing as an issue.During an interview on 9/24/25 at 12:35 p.m., staff member A stated they have identified staffing as an issue as it pertains to bathing and are working to hire more employees. Staff member A didn't think there were systemic issues that had been identified due to a lack of staffing.Review of a facility document titled QAPI PIP - Action Plan with an initiated date of 8/18/25 showed: Root Cause Identified: In

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews, and record review, the facility failed to provide services, treatment, and interventions for 1 (#1) of 18 sampled residents, who displayed physical and verbal indicators of pain and or discomfort, and verbal and physical behaviors towards others. The resident was experiencing a cognitive and functional decline, and would call out for help, or make comments of not wanting to live or being afraid. Staff failed to use identified interventions to assist the resident when she was upset or provide activities of interest. Findings include:During an interview on 9/23/25 at 8:50 a.m., staff member F stated there was not enough supervision on the memory care unit when resident #1 was going at it because she was a one-to-one. Staff member F stated that resident #1 was difficult to redirect, she would bang on things, wander, and would target (seek out and act on) other residents. When asked about the frequency of support from the activity staff for dementia related activities, staff member F said there were no activities until this week.During an observation on 9/23/25 from 5:45 p.m. to 6:10 p.m., the following was observed on the memory care unit:Resident #1 was yelling, help! She stated she was scared, and then resident #8 asked resident #1 to be quiet and told her to shut up. Resident #1 continued to yell help, but there was no staff in the area to assist or intervene. Resident #1 was pleading out loud, saying, Please, please, it hurts, it hurts. Resident #1 was hollering, Everybody leave me. Resident #1 got up from her chair, stating, I'm pooping all over everything, I'm so scared, where did [son's name] go, [sons name] come. I'm so scared, I can't see. The CNA did not come over to assist or intervene with resident #1. Resident #8 asked resident #1 to stop yelling. Resident #1 screamed that someone needed to help her. Resident #1 then stated she felt like she was going to fall and said, I feel so sick. Resident #8 pulled a chair near resident #1 and resident #1 sat down. Resident #1 stated, I want you to make me dead, I can't stay alive. Resident #1 then asked the CNA for help, stating she didn't want to die and screamed, God help me, I'm so scared.Review of resident #1's care plan showed: Focus: [Resident #1] is at risk of experiencing verbal abuse from other due to dementia related behaviors - crying, yelling that may provoke negative responses, Date Initiated 8/30/2025,Goal: Resident will be safe and supported in the facility.Interventions: Encourage [Resident #1] to participate in diversional activities if she is exhibiting behaviors - such as going for a walk, listening to gospel music, provided 1:1 support or small group activities to promote engagement, Avoid overstimulation, Monitor resident interactions with staff and peers; intervene promptly if verbal altercations occur. [sic] During the observation on 9/23/25 from 5:45 p.m. to 6:10 p.m., the CNA working did not attempt any of the person-centered, care planned interventions for resident #1 such as going for a walk, listening to gospel music, 1:1 support or small group activities to promote engagement, avoid overstimulation, monitor resident interactions with staff and peers and intervene promptly if verbal altercations occurred.During an interview on 9/24/25 at 9:41 a.m., staff member H stated resident #1 required one-to-one staffing. Staff member H stated resident #1 has a lot of outbursts, and staff must keep an eye on resident #1 constantly, because she has a tendency to get up and go. Staff member H stated there have been altercations between resident #1 and other residents.During an interview on 9/24/25 at 10:41 a.m., staff member I stated resident #1 likes it when someone to talks to her, she likes to walk in silence, and she likes to go outside in the courtyard.Review of resident #1's electronic health record diagnosis listing showed the resident had a diagnosis of Alzheimer's disease and dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety. Review of resident #1's behaviors from 8/26/25 to 9/24/25 showed:-The resident exhibited frequent crying 32 times, yelling/screaming 38 times, kicking/hitting 10 times, pushing 12 times, grabbing 11 times, Pinching/Scratching/Spitting 6 times, biting 6 times, wandering 23 times, and abusive language 2 times. Review of resident #1's activity participation documentation for August and September 2025 showed the resident participated in activities on 8/15/25 and on 9/20/25. There were no other documented activities for August or September for resident #1.Review of resident #1's admission MDS, with an ARD of 5/7/25, showed:-The resident had a BIMS of 3, a severe cognitive impairment, and was able to make herself understood and she could understand others.-The resident's mood interview, Section D of the Minimum Data Set assessment, showed resident #1 did not respond to questions A. and B., there was no total severity score assessed for her mood, and there was no staff assessment completed. The resident was unable to respond if she felt lonely or isolated from those around her.-Under section E, of the MDS, for behaviors, the resident was coded as disturbing others 1 to 3 days a week. The resident's behaviors put other at significant risk for physical injury, significantly intruded on the privacy of others and significantly disrupted the care

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, and record review, the facility failed to ensure staff were educated on the importance of Enhanced Barrier Precautions and failed to ensure staff used the appropriate Personal Protective Equipment for 2 (#s 3 and 4) of 18 sampled residents. This deficient practice increased the risk of infection for residents with urinary catheters. Findings include: During an observation and interview on 9/23/25 at 9:54 a.m., staff member E was coming out of resident #4's room, pushing a mechanical lift. Resident #4 was observed with a catheter tubing and a catheter bag. There was no PPE caddy hanging outside of resident #4's door. When asked if she used PPE during the transfer with resident #4, staff member E stated she did not use PPE, but she was going to go get the PPE supplies.During an interview on 9/23/25 at 9:57 a.m., resident #4 it would depend on who that person was, if they used PPE during the catheter care. Resident #4 stated the staff used to have PPE hanging on resident #4's door, but they took it off for some reason, and the staff have become more relaxed about using PPE.During an observation and interview on 9/23/25 at 1:43 p.m., staff member D entered resident #3's room. There was a sign outside of resident #3's room showing the need for enhanced barrier precautions to be used, and a PPE caddy was hanging outside of the door. Staff member D entered resident #3's room, and did not don PPE, and stated, I forgot you had a catheter. Staff member D assisted resident #3 with a transfer to the toilet, using a mechanical lift. Staff member D donned gloves, assisted resident #3 with pulling down her undergarments, and then lowered resident #3 to the toilet. Staff member D said she was told that day that PPE was supposed to be used for residents with catheters. Staff member D said she had worked in the hospital setting prior, and EBP was not used for catheters.During an interview on 9/24/25 at 8:46 a.m., staff member C stated she expected enhanced barrier precautions to be used for residents who had a wound, a catheter, or a multidrug-resistant organism when high-contact care tasks were performed. Staff member C stated high contact care tasks were transferring, with tasks such as making the bed, during wound care, and or cleaning.Review of the facility's policy titled, Enhanced Barrier Precautions, implemented 4/11/25, showed, .Definitions: 'Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high-contact resident care activities. [sic]. 2. Initiation of Enhanced Barrier Precautions:.b. An order for enhanced barrier precautions will be obtained for residents with any of the following:i. Wounds.and/or indwelling medical devices (e.g. urinary catheters.).3. Implementation of Enhanced Barrier Precautions:a. Make gowns and gloves available immediately near or outside of the resident's room.4. High-contact resident care activities include:. c. Transferring, d. Providing hygiene, .f. Changing briefs or assisting with toileting.10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. [sic]