STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275147	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tobacco Root Mountains Care Center	326 Madison St Sheridan, MT 59749

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. Based on interview and record review, the facility failed to protect a resident from staff to resident abuse for 1 (#5) of 10 sampled residents. Findings include:During an interview on 3/12/26 at 10:44 a.m., staff member A stated the staff were educated on abuse immediately during the investigation, which was related to a abuse allegation involving resident #5 and NF9, on 2/14/26. Staff member A stated IDT reviewed every incident and adverse events including abuse were reviewed in QAPI. The facility followed its policy in reporting and investigating abuse. NF9 was no longer employed by the facility after the investigation.During an interview on 3/12/26 at 10:57 a.m., staff member B stated she was home when she got the call from staff for an allegation of verbal abuse of resident #5 by NF9. Witness statements and the camera showed NF9 pulling the [resident #5's] walker with gestures to hurry, and the staff member directed resident #5 from the dining area to her room. Staff member B stated the provider, staffing agency, and family were notified of the alleged abuse. Staff member B stated the actions of NF9 went against the facility practice of using a gait belt and behavior and she was let go after suspension and investigation. All staff that were witnesses were educated on the requirement to intervene when witnessing potential abuse on 2/15/26. Then all staff were trained on the abuse process. During an interview on 4/1/26 at 12:18 p.m., staff member P stated that she witnessed NF9 being aggressive with resident #5 entering her room. Staff member P stated she stayed by the resident's door once she witnessed the abuse and did not leave. She did not intervene because NF9 was putting items away and was no longer touching resident #5, who was sitting in her recliner. Staff member P stated she motioned for another staff member to get the nurse. Once NF9 left the room, staff member P went to report the abuse to the nurse for what she witnessed. Staff member P stated she wrote out a witness statement and was interviewed. Staff member P stated resident #5 could be difficult with behaviors but was not different than her baseline after the incident, and was still participating in activities, going to meals, and had no changes in her routine. Staff member P stated she was disciplined for not following the policy of intervening further on the alleged abuse and had to complete online reeducation on top of in-person education for abuse. Review of the facility investigation for an abuse allegation on 2/14/26, showed a charge nurse notified staff member B on 2/14/26 at 7:00 p.m., NF9 was verbally abusing resident #5. NF9 had left right after, as it was the end of her shift. NF9 was suspended pending investigation. The allegation was reported to the State Survey Agency, as required. All staff witnesses wrote statements and were interviewed and educated on abuse reporting and the need to intervene when suspecting abuse. Staff were disciplined that did not follow the policy to intervene in suspected abuse. All facility staff were reeducated. Resident #5 was assessed, and monitoring did not show any adverse effects after the incident. NF9's contract was ended with the investigation substantiating that they did not follow facility practices on 2/15/26.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to initially report an incident of suspected resident-to-resident abuse to the State Survey Agency within the required timeframe for 2 (#s 5 and 6) of 10 sampled residents. Findings include: Review of a facility reported incident sent to the State Survey Agency, showed on 7/5/25 (a Saturday) residents #5 and #6 got into an altercation. The nurse did not immediately report the incident up the chain of command to the DON or Administrator. The delay in the nurse reporting continued the risk to the residents until the altercation was identified on 7/7/25 (a Monday) during a chart review. The facility attempted to report the initial abuse allegation on 7/7/25, but the submission was not saved. The facility did not attempt to resubmit the incident to the State Survey Agency. The facility submitted the full investigation, including the initial report, on 7/11/25. The initial report was late. During an interview on 3/12/26 at 10:44 a.m., staff member A stated the incident between residents #5 and #6 happened over the weekend and was found (the following Monday) when reviewing chart (medical record) notes. Staff member A stated they attempted to submit the initial report on 7/7/25 to the State Survey Agency. The submission did not save in the reporting system, so the full investigation, with the initial report and final investigation, was submitted on 7/11/25. Staff member A stated the nurse was reeducated of the requirement to notify the necessary staff of any incident or potential abuse immediately, and all staff had abuse reporting training. Review of facility staff abuse training logs for the last 12 months showed staff member T had completed, on 4/13/25, the course titled, Preventing, Recognizing, and Reporting Abuse.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility staff failed to proactively identify and address the risks a heater posed to a dependent resident when the heater was next to the resident's bed, and the resident sustained second degree burns on her left calf, left toes, left heel, left foot, and the entire bottom of her left foot from the heater, for 1 (#1) of 10 sampled residents; and the facility failed to address a resident's complaints of pain over a period of time after the resident had the Heimlich maneuver provided, and it was later found the resident had lower right rib fractures, for 1 (#2) of 10 sampled residents. On 3/31/26 at 4:44 p.m., the facility Administrator and Director of Nursing were notified that an Immediate Jeopardy existed in the area of F689 - Accidents and Hazards, pertaining to resident #1. The severity and scope of the IJ were identified to be at the level of J. The facility submitted an acceptable plan to remove the immediacy on 4/1/26 at 1:22 p.m., which was accepted by the State Survey Agency on 4/1/2026 at 1:45 p.m. The facility alleged the immediacy would be removed as of 4/1/26 at 2:30 p.m. Surveyors were onsite and verified the removal of immediacy as of the alleged date and time, lowering the severity and scope to G. Findings include: 1 . Resident #1 - Heater Burn Review of a facility document, titled Self-Inflicted Injury, dated 2/20/26, showed resident #1's left leg was found hanging off the bed, and it was on the baseboard heater. Two staff members moved the resident's leg back onto the bed. The resident's leg was assessed, and the resident was found to have a second-degree burn to the left leg and foot, which was draining fluid and bleeding. The resident was not responsive to verbal or physical stimuli at the time and was not able to state whether she had pain or not from the injury. The nurse placed cold rags (cloths) on the resident's wounds. Review of two witness statements, dated 2/20/26, showed resident #1 was found lying in her bed at 5:30 a.m., with her left leg hanging off the side of the bed, and it was on top of the baseboard heater. Staff member E's witness statement showed the last time she was in the resident's room was at 3:00 a.m., and this was two and a half hours prior to the resident being found with the burn. Review of resident #1's Skin Observation Tool, which was dated with an effective date of 2/20/26, showed, Second-degree burn noted on left calf and left toes. Poor skin integrity as (the resident was) actively dying. Cause identified as baseboard radiant heat as resident placed leg over bed and onto heater. [sic] The document was signed on 3/3/26, eleven days after the event and burns occurred for resident #1. During an interview on 3/11/26 at 1:45 p.m., NF5 stated that when she arrived at the facility, she had the staff unwrap resident #1's left foot and leg. NF5 stated the hospice agency called her to report the burn on resident #1's foot and leg. NF5 stated the bandage on the burn appeared new, as if it had just been placed on the resident, although the burn occurred in the early morning. During an interview on 3/11/26 at 2:56 p.m., NF7 stated staff member B called the hospice agency to inform them of the burn to resident #1's left foot and leg. NF7 stated staff member B told her the resident's leg had fallen off the bed and came to rest on the baseboard heater. Staff member B stated the resident had not experienced an increase in pain. NF7 stated that staff member B told her it was a significant burn with blistering to the left foot, from the heel to the toes. NF7 stated that the case manager for the resident, who was from the hospice agency, arrived at the facility after the resident (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	passed away. During an interview on 3/12/26 at 7:56 a.m., staff member C stated the resident regularly kept putting her leg on the heater, which was by the bed, and she did not know how long the resident's leg was on the heater (for the burn to occur). Staff member C stated, Her (#1's) leg was on the (heater) for quite a while. Staff member C stated that staff checked on the resident often, saying it was almost every hour. Staff member C stated she didn't hear about the accident with resident #1's burn until after breakfast that morning. Staff member C stated the resident was very agitated in the days leading up to her death due to the pain she had from lung cancer. Staff member C stated the resident was not able to express her pain verbally, but she expressed non-verbal signs and symptoms of pain. During an interview on 3/12/26 at 10:47 a.m., staff members A and B were interviewed together. Staff member B stated she was in the facility at the time when the incident with resident #1 was reported to her. Staff member B stated she assisted the other staff member in putting the resident's leg back on the bed, and then cool cloths were put on the resident's leg and foot. Staff member B stated that resident #1 had sustained a burn from the baseboard heater. Staff member B stated she reported the incident to the administrator and compliance. Staff member B stated that the morning meeting then took place, and the staff was divided up and assigned to complete auditing of other resident rooms and heaters. Staff member B stated that the maintenance staff checked the boiler and temperatures (for burn risk temperatures). Staff member A stated the facility camera footage (during the time preceding the resident's burn) showed the staff were active in the unit all night. Staff member A stated that hospice staff were notified of resident #1's burn incident. Staff member A stated all rooms were assessed for safety regarding the baseboard heaters, and all the furniture was moved 24 inches away from the heaters. Staff member A stated that resident #1's leg was on top of the baseboard heater which was inconsistent with other accounts of the incident. During an interview on 3/12/26 at 11:28 a.m., staff member F stated that when she came on shift on 2/20/26 at 5:30 a.m., staff member E stated to her, This is really bad, when discussing resident #1's left leg burn injury. Staff member F stated the staff was pretty shook up about the accident, and when she saw the resident, there was a lot of liquid and blood draining from the left leg burn. Staff member F stated the resident's leg did not get wrapped (for treatment) until after the resident passed away. Staff member F stated the resident's clothing and bedding had to be changed due to the amount of fluid and blood coming from the leg wound. During an interview on 3/12/26 at 11:48 a.m., staff member E stated the event with resident #1 happened when the morning shift was coming on to start their shift. Staff member E stated she had to have another staff member come assist her in getting resident #1's leg back on the bed. Staff member E stated she wrapped cool, wet cloths (rags) on the resident's foot and leg. Staff member E stated she notified staff member B of the accident, and staff member B notified the hospice nurse. Staff member E stated she left before the bedding was changed. Staff member E stated the resident required a two-person assist with turning and repositioning. Staff member E stated she had gone home before the arrival of the hospice nurse, and stated the resident was actively dying and had received morphine every two hours through the night. Staff member E stated the resident passed away a short time after the accident/incident. During an interview on 3/30/26 at 3:34 p.m., NF8 stated resident #1 was seen daily by hospice. NF8 stated she was on call the day resident #1's burn occurred, and she immediately traveled to the facility. NF8 stated resident #1 had passed away before she arrived. NF8 stated she unwrapped the burn on resident #1's foot and found, a significant second degree burn from her toes to her heel (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	into the room at 5:30 a.m. and found resident #1's foot was wedged in the heater, and she needed assistance to get the foot out. During an interview on 3/31/26 at 7:36 p.m., staff member C stated resident #1 was agitated, was moving a lot, and did not like being in bed. Staff member C stated that when she worked, she was always in resident #1's room every hour because She was so antsy and moving her legs around. During an interview on 4/1/26 at 9:30 a.m., staff member J stated, [Resident #1] would swing her legs off the bed a lot, we were always repositioning her legs. Staff member J stated she was not aware the heater was a concern. Review of a document, titled Burn Injury Identification and Prevention, dated 2/20/26, showed resident #1 was found at 5:25 a.m. with her left leg hanging off the bed, and it was on top of the baseboard heater. Review of resident #1's medication administration record, dated 2/9/26 through 2/20/26, showed the resident's morphine was changed on 2/19/26, from an as-needed medication to a scheduled medication, and it was to be given every two hours for shortness of breath and pain. This was due to non-verbal signs of pain such as being uncomfortable, sitting forward, fussing around her back and lungs, and restlessness. The resident was lethargic and unable to state the need for pain medication at times, and she was restless and grimacing at times. The resident went in and out of responsiveness but was not able to express pain verbally. Review of resident #1's Treatment Administration Record, for turning and repositioning, dated 2/1/26 through 2/28/26, showed turning and repositioning on 2/19/26 and 2/20/26. Nine entries were documented at 5:09 p.m., four entries were documented at 5:10 p.m., three entries were documented at 3:57 a.m., and two entries were documented at 9:01 p.m. This reflected there were four documented times out of 24 opportunities for the resident's turning and repositioning. There was no further documentation provided for the turning and repositioning of resident #1, showing the resident was being checked on for her positioning. Review of resident #1's care plan, dated 2/10/26, showed nursing staff were to evaluate the effectiveness of pain interventions every shift, monitor and document for probable cause of each pain episode, monitor and document side effects of pain medication, monitor and document signs and symptoms of non-verbal pain, monitor and record loss of appetite, and monitor and record the resident's complaints of pain. There was nothing on the care plan for resident #1 related to the risk of burns from the heater prior to the accident occurring, although the resident had a history of moving her legs and placing them on the heater, per staff. Review of resident #1's, Pain assessment vitals, dated 2/10/26 - 2/20/26, showed: 2/20/26 at 12:30 a.m., rated as 6/10, moderate pain, 2/20/26 at 3:05 a.m., rated as 3/10, mild pain, 2/20/26 at 5:45 a.m., rated as 0/10, no pain Review of the facility surveillance video, dated 2/20/26 from midnight to 5:30 a.m., showed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- 1:07 a.m., staff member E entered resident #1's room, with medication and exited within one minute, - 1:49 a.m., staff member E entered resident #1's room and exited within one minute, - 3:36 a.m., staff member M entered to drop off water and exited within one minute - 4:48 a.m., staff member M entered resident #1's room and exited in 11 seconds, and - 5:24 a.m., staff member E entered resident #1's room and exited after 7 minutes when the wound was reportedly found. The video failed to show the nurse entering the room every two hours and failed to show the CNA checking on the resident every 30 minutes. The last person to enter resident #1's room was staff member M at 4:48 a.m., until 5:24 a.m., when resident #1's foot was found wedged in the heater. During an interview on 3/11/26 at 1:41 p.m., NF6 stated resident #1's left leg was wrapped when she picked her up and transported her to the funeral home. NF6 stated she did not see a burn on the resident's foot/leg due to the foot/leg being wrapped. 2. Resident #2 - Rib Fractures During an interview on 3/11/26 at 2:24 p.m., NF1 stated they were in the dining room assisting another resident eating when a dietary staff member said something looked wrong with resident #2. NF1 stated there were two other nursing staff members present, but the nurse hesitated. NF1 stepped in to perform the upward thrust (Heimlich) to stop resident #2 from choking. NF1 stated they were not sure how weak resident #2 was, so he was left in the chair, and then the upward thrust around the chair was performed. NF1 stated resident #2 had the correct diet provided, but believed the diet was changed after a second choking incident occurred, and the upward thrust was performed a second time. NF1 stated they wrote a handwritten witness statement on the details for the first choking incident for resident #2 when he provided the upward thrust for the resident. During an interview on 3/11/26 at 2:49 p.m., NF2 stated resident #2 was placed on hospice after a bad fall in December 2025, where the hospital found the resident had complex pelvis fractures and rib fractures, and the family elected not to do surgery on the resident. During an interview on 3/12/26 at 8:32 a.m., staff member D stated resident #2 had a regular diet and had choked, and someone performed the Heimlich maneuver on the resident. After a second choking incident, the facility downgraded the resident's diet. The resident was placed on hospice after this event. Staff member D stated resident #2 did have right rib fractures found on the x-rays from the hospital visit for a later fall, with a pelvis fracture, but there were no X-rays done after the choking incidents when the resident complained of rib pain. Staff member D stated resident #2 was very confused during this time, and throughout the period when he was passing (end of life changes). During an interview on 3/12/26 at 10:16 a.m., staff members A and B stated after resident #2 choked, and they were in the process of reviewing the incident information and details, when he had another choking incident. Staff member B found resident #2 had a medication, Reglan, discontinued before the choking incidents occurred, because the provider believed it was contributing to the resident's insomnia, and none of the facility staff were aware of why he was taking the medication. They reordered the medication after the second choking incident, then the resident's diet was downgraded (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-12/1/25 at 1:26 p.m., resident #2 was still reporting right rib pain which was tolerable with Tylenol. There were no further notes showing the responsible party was recontacted about the pain or sending the resident out for an evaluation of the pain. -12/2/25, a second choking incident occurred at breakfast, and resident #2 needed the Heimlich maneuver to be used again. The provider ordered the staff to monitor the resident for pain. -12/3/25, resident #2 continued to complain of right rib pain. -12/4/25, resident #2 continued to complain of right rib pain and declined going to the hospital. The notes did not show the responsible party was contacted, due to the resident's cognitive impairment, to see if they wanted the resident to be assessed further for the pain. -12/5/25, resident #2 continued to complain of right rib pain and requested to see the provider in the clinic the following day. -12/5/25, resident #2 fell in the bathroom and hurt his left hip. He was sent to the ER and came back with an identified injury, which was a complex pelvis fracture. The hospital also identified the right 6th and 7th nondisplaced rib fractures. Review of the hospital discharge records for resident #2, on 12/5/25, showed he was found to have nondisplaced fractures of the right 6th and 7th ribs. Review of resident #2's MAR, from 11/28/25 through 12/5/25, showed he was given a PRN Tylenol, 650 mg, on 11/30/25, for a pain level of 4/10, and again on 12/1/25, for a pain level of 6/10. No further pain medication was provided. Review of resident #2's vital signs for a pain level ranging from 0-10 (10 being the worst) from 11/28/25 through 12/5/25, showed: -11/28/25, none documented. -11/29/25, none documented. -11/30/25 at 7:30 a.m., numerical pain level of 4. -11/30/25 at 7:57 a.m., numerical pain level of 3. -12/1/25 at 7:40 a.m., numerical pain level of 6. -12/1/25 at 12:18 p.m., numerical pain level of 3. -12/2/25, none documented, and the 2nd choking incident occurred this day. -12/3/25, none documented, although the nurse documented the resident had pain in the progress notes. -12/4/25, none documented, although the nurse documented the resident had pain in the progress notes. (continued on next page)

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	275147	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tobacco Root Mountains Care Center	326 Madison St Sheridan, MT 59749

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-12/5/25 at 10:48 a.m., numerical pain level of 8. -12/5/25 at 10:55 a.m., numerical pain level of 8. Review of the facility policy, Terminal, Dying Resident, Caring for the, dated 10/26/25, showed: - .8. As the resident approaches death, monitor him or her frequently. Report all changes in the resident's condition to the Nurse promptly. 24. Try to be with the resident as much as possible during this time. Review of the facility policy, Pain Assessment and Management, dated 10/2022, showed: - .Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. Review of the facility policy, titled Repositioning, with a revision date of 2/2/26, showed: .14. A turning/repositioning program includes a continuous consistent program for changing the resident's position and realigning the body. A program is defined as a specific approach that is organized, planned, documented, monitored and evaluated . 16. Residents who are in bed should be on at least an every-two-hour (q2 hour) repositioning schedule . 19. If ineffective, the turning and repositioning frequency will be increased .

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure adequate pain management for 2 (#s 1 and 2) of 10 sampled residents. This deficient practice resulted in residents #1 and #2 having moderate and severe pain during the last day of life. Findings include:1. During an interview on [DATE] at 7:53 a.m., staff member N stated resident #1 was always in a lot of pain when staff did checks and changes.During an interview on [DATE] at 4:10 p.m., staff member O stated she and the physician were doing walking rounds, and the physician wanted resident #1 to have PRN pain medications immediately due to signs of significant pain. Staff member O stated she had notified staff member B, who then instructed the floor nurse to administer pain medication immediately. Staff member O stated the floor nurse did not administer the PRN pain medication for more than four hours after she was told to give the PRN medication. Staff member O stated the floor nurse was fearful of giving the pain medication because she had been reprimanded the prior day for giving too much PRN pain medication to a resident. Therefore, the resident's pain was not addressed in a timely manner. During an interview on [DATE] at 8:03 a.m., staff member J stated she second-guessed herself about giving resident #1 pain medications because she had been told she was giving too much pain medication to a resident the prior day. Staff member J stated resident #1 would mumble what she thought was no when asked if she was in pain, but her grimacing face indicated she was in a lot of pain. Staff member J stated resident #1 was not very verbal, and non-verbal indicators such as facial expressions were used to indicate signs of pain, but she always asked the resident as well. During an interview on [DATE] at 9:03 a.m., staff member J stated resident #1's medication orders were a debacle. Staff member J stated orders were not matching, and the facility was not getting the medications. Review of resident #1's, Pain assessment vitals, dated [DATE]-[DATE], showed:[DATE] at 12:30 a.m., rated as 6/10, moderate pain, for which pain medication was administered at 1:07 a.m. per video below[DATE] at 3:05 a.m., rated as 3/10, mild pain, no intervention[DATE] at 5:45 a.m., rated as 0/10, no pain, no interventionReview of the facility surveillance video, dated [DATE] from midnight to 5:30 a.m., showed the following:- 1:07 a.m., staff member E entered resident #1's room and exited within one minute, with medication,- 1:49 a.m., staff member E entered resident #1's room and exited within one minute,- 3:36 a.m., staff member M entered to drop off water and exited within one minute,- 4:48 a.m., staff member M entered resident #1's room and exited within 11 seconds, and- 5:24 a.m., staff member E entered resident #1's room and exited after seven minutes, when the wound was reportedly found.The video failed to show staff member E entering the room every two hours or 30-60 minutes after each medication administration, and failed to show staff member M checking on the resident every two hours. 2. Review of resident #2's EHR progress notes, dated [DATE]-[DATE], showed the following:- [DATE]: Resident #2 was found lying on the floor of his neighbor's room. He was lying on his right side but complained of pain in his left hip. Upon assessment, resident #2 was unable to move without crying out in pain. Due to the resident crying out if moved 911 was called. Notes indicate resident #2 had a complex pelvic fracture and rib fractures, but the family opted not do surgical procedures. Resident #2 returned to the facility on [DATE] on comfort care. Family requested hospice services on [DATE]. [Hospice Agency] called back on [DATE] and reported they would continue to work on the referral on Monday, [DATE]. Resident #2 admitted with Hospice services on [DATE].- [DATE]: Resident #2 was complaining of pain and agitated, trying to crawl out of bed and pulling on his foley catheter.- [DATE]: Resident #2 complained of left hip/leg pain at 7:00 p.m., and he was given his scheduled pain medication, which was ineffective. At approximately 9:00 p.m., the patient was still having pain; PRN morphine, repositioning, and a lidocaine patch were all ineffective. The patient was given another PRN dose of morphine at approximately 11:00 p.m., which was also ineffective. At 1:00 a.m., the patient was given a PRN dose of oxycodone, which was finally effective, and the patient was able to rest after that. - [DATE] at 2:45 p.m.: Resident agitated and (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	calling out most of the afternoon and unable to redirect. He was offered snacks, repositioned, and given PRN pain meds, and they were ineffective. Hospice was contacted about PRN anxiety/agitation medications, and no order was received; hospice just increased Risperdal to twice daily. - [DATE] at 3:54 p.m.: Resident #2 was yelling and trying to throw himself on the floor and was unable to be redirected. PRN pain medicine was ineffective. Snacks and repositioning were ineffective. Called hospice, and no PRNs or new orders were received. Hospice called back at 4:01 p.m. and gave an order for Haldol. - [DATE]: Contacted hospice agency regarding the resident's status. Reported that [resident #2] did not fall asleep until 5:00 a.m. and required one-to-one assistance. As reported by the charge nurse, resident #2 was agitated, attempting to throw himself on the floor, cursing, and attempting to pull his catheter out. Resident #2 was experiencing delusions: talking about going to get in his pickup to go pick up an order at the cafe, wanting to show staff his new 4-[NAME] sitting outside the facility. Reported resident #2 was not eating or drinking much. Reported resident #2 received three doses of Haldol last evening, without effective results. Discussed that Ativan was discontinued, but unsure why it was not available. Discussed Lexapro being stopped. Hospice would fax new orders to clarify the Haldol order and restart Ativan. Hospice will present issues the resident is having at Hospice's Friday morning meeting and will address his need for Lexapro versus Risperidone, and his continued need for his catheter. Hospice will return on Friday for an in-person visit and bring medications for a refill. New orders and updated orders will be put into PCC as they come. Hospice restarted lorazepam oral concentrate for anxiety PRN. - [DATE]: Hospice stated they talked about restarting the resident's Lexapro in their morning meeting; however, they would like to give Risperdal time to reach a therapeutic level first. No medication changes given.- [DATE]: Resident sleeping in bed most of the evening. Began to move around and holler help around 11:00 p.m. Morphine was administered at 11:20 p.m., and the resident stated it was effective at first, but then would call out, looking distressed and trying to sit up while belching. He motioned that the pain was mid-chest. He continued to be restless. Ativan was administered at 12:05 a.m. He continued to be restless. Mag-al was administered for signs of indigestion and appeared to be ineffective. Additional morphine was administered at 12:40 a.m. This did not help as well. The nurse and another staff member assisted him to the toilet with no results. The resident then agreed to be placed in his recliner. - [DATE] at 4:06 a.m.: Resident #2 was restless this shift. He was calling out and attempting to get out of bed and/or recliner most of the night. Fluids were offered, but the resident was unable to swallow. The mouth was swabbed and moistened for comfort. Reaching out and yelling, help me! PRN medications were administered as ordered and repositioned often. Staff attempted to console constantly. Minimally effective. - [DATE] at 8:49 a.m.: Resident #2 was super restless, moaning and agitated; gave morning oxycodone and PRN morphine at 8:15 a.m. and was ineffective, still moaning and grimacing. Hospice was notified about pain management and about the resident's fall last night. Oxycodone liquid was getting too hard for the resident to swallow the amount of liquid. Hospice stated they were going to get back to the facility. - [DATE] at 10:07 a.m.: Resident #2 was still agitated and restless; moaning and grimacing grabbing at staff; requiring one-to-one staffing. Resident #2 was repositioned, and PRN Ativan was given at 10:00 a.m. - [DATE] at 12:12 p.m.: Hospice arrived, and the facility received new orders to change morphine from PRN to scheduled every three hours and add Biotene PRN up to five times a day for dry mouth; hold Ativan and discontinue oxycodone. - [DATE] at 1:30 p.m.: Resident #2 was groaning and grimacing in recliner. He was repositioned and oral swabs done. No PRN medications were available. Next scheduled pain medications were available at 3:00 p.m. - [DATE] at 2:05 p.m.: Hospice aware and wants to give scheduled morphine time to work. - [DATE] at 12:13 a.m.: Resident passed away at 11:48 p.m.During an interview on [DATE] at 4:10 p.m., staff member O stated she re-admitted resident #2 after his fall on [DATE]. Staff member O stated he was very agitated, trying to pull his catheter out, and only had morphine and Ativan on orders. Staff member O stated the Ativan had expired, and she contacted the physician for a new order. Staff member O stated the physician was upset that he would need to return to the hospital to (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	write an e-script and wanted her to use the expired medication. Staff member O stated she refused to use the expired medication and had to wait for the new medication to arrive. Staff member O stated she was present when resident #2 passed away. Staff member O stated resident #2 was very agitated and in pain, requiring three CNAs to help keep him in the Geri chair in the hallway. Staff member O stated the only medication resident #2 had available was Phenergan suppositories. Staff member O stated she did call and talk to the hospice case manager nurse, but she was rude and not helpful, so she called over to the hospital on-call physician to get orders. Staff member O stated she was later told she cannot call the on-call physician when the resident is on hospice services.During an interview on [DATE] at 8:03 a.m., staff member J stated that resident #2, was always in so much pain. Staff member J stated she would give the medications if they were ordered, and then kept trying non-pharmacological interventions. Staff member J stated she did not attempt to call the physician, Director of Nursing, or the Hospice agency for additional pain management medications. Staff member J stated she thought the day shift nurse had contacted the physician and made the plan with the new medications, and she did not feel she should call in the middle of the night to change the medications again. Staff member J stated she did not know she could contact hospice when resident #2 was in pain on the night shift. Staff member J stated she received no training on the process of dealing with hospice residents or end-of-life residents. Staff member J stated she was new and had no experience with end-of-life care and death.During an interview on [DATE] at 1:25 p.m., staff member B stated staff member J had not had training on end-of-life care or hospice. Staff member B stated, We have a training opportunity here. Staff member B stated her expectation was that the nurses should administer medications as ordered and reassess in 30-60 minutes, continuing to get medications and non-pharmacological interventions until pain was relieved. If all options were exhausted, staff member B stated she expected the nurses to contact the appropriate on-call nurse, her, or the on-call physician, depending on each patient's situation. Review of resident #2's EHR Pain vitals, dated [DATE], reflected:[DATE] at 2:57 a.m.: 10/10 pain, maximum severe pain,[DATE] at 10:18 a.m.: 6/10 pain, moderate pain,[DATE] at 2:20 p.m.: 8/10 pain, severe pain, and[DATE] at 5:25 p.m.: 5/10 pain, moderate pain.A request for review of surveillance video was made on [DATE] at 10:30 a.m. Staff member A stated the video was no longer available before [DATE].During an interview on [DATE] at 1:25 p.m., staff member B stated she did not know why the care plan was missing in the EHR for resident #2. Review of the facility policy, Pain Assessment and Management, dated 10/2022, showed:- .Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained.- . Monitoring: 5. Contact the prescriber immediately if the resident's pain or medication side effects are not adequately controlled.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interviews and record review, the facility failed to ensure nurses were competent to provide pain management for hospice and end-of-life care for 2 (#s 1 and 2) of 10 sampled residents. This deficient practice resulted in unnecessary pain for residents #1 and #2. Findings include:1. During an interview on 3/31/26 at 4:10 p.m., staff member O stated she and the physician were doing walking rounds, and the physician wanted resident #1 to have PRN pain medications immediately due to signs of significant pain. Staff member O stated she notified staff member B, who then instructed the floor nurse to administer pain medication immediately. Staff member O stated the floor nurse did not administer the PRN pain medication for more than four hours after she was told to give the PRN medication. Staff member O stated the floor nurse was fearful of giving the pain medication because she had been reprimanded the prior day for giving too much PRN pain medication to a resident. During an interview on 4/1/26 at 8:03 a.m., staff member J stated she second-guessed herself about giving resident #1's pain medications because she had been told she was giving too much pain medication to a resident the prior day. Staff member J stated resident #1 would mumble what she thought was no when asked if she was in pain, but her facial grimacing expressions showed she was in a lot of pain.2. During an interview on 4/1/26 at 8:03 a.m., staff member J stated resident #2 . was always in so much pain. Staff member J stated she would give the medications that were ordered and would then keep trying non-pharmacological interventions. Staff member J stated she did not attempt to call the physician, Director of Nursing, or the Hospice agency for additional pain management medications. Staff member J stated she did not know she could contact hospice when resident #2 was in pain during the night shift. Staff member J stated she received no training on the process of dealing with hospice residents or end-of-life care. Staff member J stated she was new and had no experience with end-of-life care and death.Review of resident #2's EHR Pain vitals, dated 8/16/25 - 1/9/26 reflected:1/9/26 at 2:57 a.m.: 10/10 pain, maximum severe pain,1/9/26 at 10:18 a.m.: 6/10 pain, moderate pain,1/9/26 at 2:20 p.m.: 8/10 pain, severe pain, and1/9/26 at 5:25 p.m.: 5/10 pain, moderate pain.A request was made on 4/1/26 at 12:20 p.m., for education and training for staff member J for hospice and end-of-life care. During an interview on 4/1/26 at 1:25 p.m., staff member B stated staff member J did not have training on end-of-life care or hospice (from the facility). Staff member B stated, We have a training opportunity here. The nurses should contact the hospice or the on-call nurse. Staff member B stated her expectation was that the nurses should administer medications as ordered and reassess the resident in 30-60 minutes, continuing to provide medications and non-pharmacological interventions until pain was relieved. If all options were exhausted, staff member B stated she expected the nurses to contact the appropriate on-call nurse, her, or the on-call physician, depending on each patient's situation. Staff member B stated the facility recently changed the training to Relias (training program) and was just starting to assign training. The training would be spread out over a 12-month period. Staff member B stated Relias did have courses covering pain management and end-of-life care, but she had not assigned them to the nurses yet. Review of staff member J's employee file reflected that no education was provided from the facility on hospice care or end-of-life care. Review of the facility Assessment Tool, updated 12/15/25, showed:- . Training in an ongoing process for all staff. The following in services/Relias trainings are assigned during the year to ensure all staff are knowledgeable on these topics.- .Hospice, End of Life Care.