STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275159	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beartooth Rehabilitation and Nursing LLC	350 W Pike Ave Columbus, MT 59019

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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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(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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on interview and record review, the facility failed to recognize and protect a resident's right to be free from neglect, following a resident's major injury from an unwitnessed fall, and the resident had severe cognitive impairment; for 1 (#4) of 12 sampled residents. The deficient practice resulted in the resident experiencing pain, was not thoroughly assessed after the fall, and there was a delay in timely care, which resulted in the resident's surgery and hospitalization. Findings include:During an interview on 8/26/25 at 10:04 a.m., staff member A stated she had been working and fulfilling the roles of Administrator, Social Services Designee, and the Business Office Manager for the facility. Staff member A stated she was also working as the Grievance Officer and Abuse Prevention Coordinator, for now. Staff member A stated she was not aware of issues in the facility related to quality-of-care concerns that would require reporting or investigating an event as a facility-reported incident, such as for resident #4's unwitnessed fall with a significant injury. Staff member A stated the ultimate responsibility was on her for responding to incidents and those processes.During an interview on 8/26/25 at 4:08 p.m., staff member B stated she and staff member A were the two main members of the interdisciplinary (IDT) team, and staff member A would work on reportables (facility reported events). Staff member B stated she did not know of any reportable incidents the facility had submitted to the State Survey Agency.During an interview on 8/27/25 at 3:11 p.m., staff member A stated she had not submitted a facility-reported incident to the State Survey Agency within the last six months. Staff member A stated she had a trigger call with staff member O to review the fall event that occurred with resident #4 on 4/10/25. Staff member A stated she was advised by staff member O not to submit the event information for resident #4's fall to the State Survey Agency as a facility-reported incident. The facility neglected to report the resident's unwitnessed fall with a significant injury to the State Survey Agency and the resident was an unreliable reporter of the event.During an interview on 8/28/25 at 8:02 a.m., staff member M stated she received the shift change report from staff member N the morning resident #4 was transferred out of the facility by EMS. Staff member M stated that staff member N told her that resident #4 had a fall and was in a lot of pain. Staff member M stated she did not know what the staff did for the resident through the night. Staff member M stated she asked staff member N why resident #4 was not sent out to the hospital for a medical evaluation after the fall, and he stated staff member B told him not to send her. Staff member M stated she entered resident #4's room and saw resident #4 in bed, moving around, making facial grimaces. Staff member M stated she checked resident #4 in the bed and noticed she was wet (incontinent). Staff member M stated that, with the help of other staff, she rolled resident #4 to her side to change her. Staff member M stated she heard a loud sound from resident #4's left leg. Staff member M stated she could see the resident's condition and called EMS for assistance.During an interview on 8/28/25 at 12:24 p.m., staff member L stated the nurse, another staff member, and she went over to the dining room and found resident #4 lying on the floor, after being told by a kitchen staff member that the resident had a fall. Staff member L stated they picked the resident up manually, neglecting to use a mechanical lift, then put her in a wheelchair and took her to her room. The staff then manually transferred the resident to her bed, again neglecting to use a mechanical lift. Staff member L stated that when they tried to remove resident #4's pants, she began to fight due to being in pain, and she showed signs of pain. Staff member L stated she let staff member N know about her concerns with resident #4. Staff member L stated that staff member N told her he had been in contact with [Staff member B] and was told not to send the resident to the hospital. Staff member L relayed that staff member N said the hospital would just send the resident back if she were sent out. Staff member L voiced her discomfort with the decision and situation.During an interview on 9/2/25 at 9:14 a.m., NF3 stated he received a call from a male nurse the night of 4/10/25. NF3 stated the nurse told him resident #4 had fallen from her bed, that she might have rolled from bed. NF3 stated he asked the nurse if it was serious and if he should come over to check on her. NF3 stated the nurse told him no, and he just wanted to notify NF3 of the fall and transfer back to bed. NF3 mentioned he was concerned about resident #4 being in pain. The information relayed in the phone call, by the nurse, was not an accurate account of the fall events when resident #4 was found on the floor in the dining room. NF3 was provided with inaccurate information and the staff member neglected to provide an accurate account of the events that occurred or the resident's status.During an interview on 9/3/25 at 6:06 p.m., staff member N stated he was the nurse on duty the night resident #4 fell on 4/10/25. Staff member N stated a kitchen staff member told him resident #4 had fallen in the dining room and was lying on the floor. Staff member N stated he walked down to the dining

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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 Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 Note: The nursing home is disputing this citation.	Based on interview and record review, the facility failed to implement and uphold policies and procedures for the reporting of an unwitnessed fall, for a resident who was not a reliable reporter, and the resident sustained a hip fracture, had surgery, and was hospitalized for it, or 1 (#4) of 6 residents sampled for falls; and facility staff neglected to provide necessary services to the resident after the fall, which was not identified as neglect of care, and reported to the State Survey Agency following the event. Findings include:On 8/25/25, it was identified that the facility had no documented facility reported incidents submitted to the State Survey Agency. The facility was not able to provide any prepared or completed investigations for any facility reported events submitted to the State Survey Agency. The facility had an initial certification survey in December 2024, and a complaint survey in July 2025, and no reportable events were submitted to the State Survey Agency iduring this time. During an interview on 8/26/25 at 10:04 a.m., staff member A stated she had been working in the roles of Administrator, Social Services Designee, and Business Office Manager for the facility. Staff member A stated she was also working as the Grievance Officer and the Abuse Prevention Coordinator, for now. Staff member A stated she was not aware of issues in the facility related to quality-of-care concerns that would require reporting and investigating as a facility reported incident. Staff member A stated if a resident or family had complaints or issues, she worked to take care of them right in the moment. Staff member A stated when she worked on things, she might get caught up and not have a chance to write them down. Staff member A stated, It's not my strong point documenting things. Staff member A stated the ultimate responsibility went to her for responding to incidents and those processes. It was identified staff member A was not completing the required tasks.During an interview on 8/26/25 at 4:08 p.m., staff member B stated staff member A would work on reportables (events sent to the State Survey Agency). Staff member B stated she did not know of any reportable incidents the facility had submitted. Staff member B stated an unwitnessed injury had happened to a resident, where she and staff member A consulted with staff member O. Staff member B stated the injury was a fall with a hip fracture, and she reviewed the information with staff member O, advised not to submit the event to the State Survey Agency as a facility-reported incident. During an interview on 8/27/25 at 3:11 p.m., staff member A stated she had not submitted a facility-reported incident to the State Survey Agency within the last six months, which would include the event for resident #4's fall with unknown injury on 4/10/25, and the resident was an unreliable reporter. Staff member A stated she had access to Bounds (electronic reporting system), but that the list on Bounds had changed, and it seemed like it was a year without access to Bounds. Staff member A stated she had a trigger call with staff member O to review the event that occurred to resident #4 on 4/10/25. Staff member A stated she questioned the event and appreciated knowledge from nursing staff on the clinical side of things. Staff member A stated she was advised by staff member O not to submit the event information to the State Survey Agency as a facility-reported incident.Review of resident #4's nursing progress notes, with an entry by staff member N, which was stricken through and dated 4/10/25 at 23:21 (11:31 p.m.), showed: Incorrect Documentation -Note Text: .1900 kitchen staff contacted nursing staff that Res. had fallen in the dining room. Upon arriving to the dining room staff found the Res. on the floor laying on her Rt. side. Res. stated that she hit her head when asked. She was asked if she hurt anywhere else and she did not respond. She had a large hematoma on the back of her head and a large skin tare on her Lt. forearm. When staff tried to assist her to sit up she complained of severe pain in her Lt. hip/femur area. EMT was called for transport. DON was contacted and the DON told the nurse not to transport at this time. EMT was canceled. Res. was assisted to a W/C and then into her bed. Admin. Was also contacted and recommended that we observe Res. and get an order for a portable X-Ray in the morning. V/S & Neuros were started per protocol. The POA & Provider were also contacted. [sic]There were no other nursing progress notes from staff member N documented for 4/10/25 or 4/11/25, after the entry was struck from resident #4's record. Review of resident #4's nursing progress notes, dated 4/11/25 at 6:29 a.m., showed: Upon assessing resident, resident on her back in bed with arms across chest. Resident stated she was in pain when asked, 6/10 pain per painaid. EMS was notified of a broken hip. DON and admin notified. Resident with urine-soaked clothes, sheets and pad. Clothes were removed and resident was cleaned up, upon turning resident a loud pop was heard from left hip. EMS arrived at 0625 (6:25 a.m.) [sic]An initial request was made to the facility for an incident reporting policy on 8/25/25 at 2:18 p.m. A second request was made to the facility for an incident reporting policy on 8/27/25 at 4:30 p.m. Staff member A stated the facility had a section in the Abuse and Neglect

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate an abuse or neglect investigation following an event when a resident experienced an unwitnessed fall resulting in major injury, which required surgery and hospitalization for 1 (#4) of 6 residents sampled for falls, and the licensed nursing staff failed to ensure the resident was provided necessary care and services related to the fall and negative outcomes from it, or follow the facility policies or procedures, or standards of practice for nursing care. This deficient practice caused a delay of the allegation of abuse or neglect being sent to the State Survey Agency and increased the risk for residents in the facility due to the facility not identifying, thoroughly investigating, and failing to report facility reported events. Findings include:On 8/25/25, the facility was under inspection for a complaint and revisit survey, and it was noted that there were no documented facility reported incidents that were either reported or submitted to the State Survey Agency. The facility did not have any prepared reports or incidents to review for tracking and monitoring events in-house over time. The facility had an initial certification survey in December 2024 and a complaint survey in July 2025.During an interview on 8/26/25 at 10:04 a.m., staff member A stated she was also working as the Grievance Officer and the Abuse Prevention Coordinator, besides her other roles. Staff member A stated that she and staff member B would handle medical records. Staff member A stated she was not aware of issues in the facility related to quality-of-care concerns that would require reporting and investigating as a facility reported incident. Staff member A stated if a resident or family had complaints or issues, she worked to take care of them right in the moment. Staff member A stated that when she worked on things, she might get caught up and not have a chance to write them down. Staff member A stated, It's not my strong point documenting things. Staff member A stated the ultimate responsibility went to her for responding to incidents and those processes. During an interview on 9/2/25 at 4:05 p.m., staff member B stated, I had a trigger call with corporate after the incident occurred and was advised by our corporate nurse that I did not have to report the fall to the state. I used to work for a company that had us report all falls, so I was a little nervous about not reporting it. Staff member B stated the interdisciplinary team talked about resident #4's fall, but no investigation was completed because it did not need to be reported. Staff member B stated an investigation is not completed unless we are told by corporate to do one. During an interview on 9/2/25 at 4:42 p.m., Staff member E stated, We did not have them report the fall because it does not meet the criteria for a reportable. Staff member E stated, [Resident #4's] injuries were not suspicious, so they are not required to be reported and investigated.During an interview on 9/4/25 at 9:04 a.m., Staff member A stated all staff are provided abuse and neglect training, at a minimum yearly, and that included administration staff. Review of resident #4's nursing progress notes, dated 4/11/25 at 6:29 a.m., showed: Upon assessing resident, resident on her back in bed with arms across chest. Resident stated she was in pain when asked, 6/10 pain per painaid. EMS was notified of a broken hip. DON and admin notified. Resident with urine-soaked clothes, sheets and pad. Clothes were removed and resident was cleaned up, upon turning resident a loud pop was heard from left hip. EMS arrived at 0625 (6:25 a.m.) [sic]Review of resident #4's nursing progress notes, dated 4/16/25 at 12:30 p.m., showed: Resident readmitted today via ambulance from [NAME] and 2 paramedics. Fractured left hip with ORIF performed and blood clots to left leg and right lower lobe of lung. Alert and oriented to self. Remains very confused. Has been in bed since arrival. Refusing all medications, to be moved, and care. An initial request was made to the facility for an incident reporting policy on 8/25/25 at 2:18 p.m. A second request was made to the facility for an incident reporting policy on 8/27/25 at 4:30 p.m. Staff member A stated the facility had a section in the Abuse and Neglect Policy for incident reporting information.The facility did not initiate or document a completed investigation of the event which occurred with resident #4 on 4/10/25 to submit for review by the State Survey Agency. The facility did not complete investigative steps to include interviews with resident #4, witnesses, other residents, and staff members responsible for resident #4's care during the event to assess and determine whether there were details or patterns of behavior with any of those involved, or determine if necessary care was provided to the resident with the fall and injury.Review of a facility policy titled, Abuse, Neglect and Exploitation, dated 4/11/25, showed: .VII. Reporting/ResponseA. The facility will have written procedures that include: . 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(s) to determine why abuse, neglect. occurred, and what changes are needed to prevent further occurrences B. The administrator will follow up

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a routine written notification of a resident transfer and discharge was completed and maintained, with information regarding the transfer and discharge to the local Ombudsman for 4 (#s 3, 4, 10, and 12) of 12 sampled residents reviewed for a transfer and or discharge from the facility. The deficient practice increased the risk of residents being inappropriately transferred or discharged due to the lack of communication to the resident or advocate. Findings include:Review of a facility list of resident transfers and discharges, dated 8/25/25 at 3:31 p.m., showed:- Resident #4 transferred to a hospital on 4/11/25.- Resident #12 transferred to a hospital on 6/20/25.- Resident #10 transferred to a hospital on 5/4/25 and 6/17/25; and,- Resident #3 discharged from the facility on 8/8/25 due to the resident's death.During an interview on 8/26/25 at 10:33 a.m., NF1 stated staff member A did not send her the notices for the resident transfers and discharges. NF1 stated that staff member A mentioned to her that resident #3 was discharging from the facility, due to the resident's death. NF1 stated she asked for the discharge and transfer notices to be sent to her, by staff member A, and that did not happen after she made the request. During an interview on 8/26/25 at 2:30 p.m., staff member A stated she did not have any copies of the resident transfers and or discharges that were the notifications sent to NF1. Staff member A stated, I don't email them, I mail them to [NF1], I don't have secured email. I can start sending them by certified mail.During an interview on 9/2/25 at 9:58 a.m., NF1 stated the transfer and discharge notices hadn't been sent to her by staff member A for months. NF1 stated NF1 stated she usually received monthly notices from other facilities for the resident transfers and discharges.Review of a facility policy titled, Transfer and Discharge (including AMA), dated 4/11/25, showed: .Policy Explanation and Compliance Guidelines: .4. Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is effected because: .e. In these exceptional cases, the notice must be provided to the resident, resident's representative if appropriate, and LTC Ombudsman as soon as practicable before the transfer or discharge. 5. The facility will maintain evidence that the notice was sent to the Ombudsman.10. Emergency Transfers to Acute Care.h. The Social Services Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notices.A request for the evidence of the facility notifications to the Ombudsman for the resident transfers, discharges, or bed holds, from January 2025 to the present date, was made on 9/2/25 at 10:55 a.m. A document was provided, which was sent from staff member A to NF1, on 9/3/25 at 2:48 p.m., and it included a listing of resident transfers and discharges from 9/2/24 to 8/8/25.

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on observation, interview, and record review, the facility failed to complete a Significant Change MDS for a resident's decline, for 1 (#4) of 12 sampled residents. This deficient practice increased the risk of the resident not receiving necessary care due to the lack of changes being identified using the MDS assessment process. Findings include:During an observation on 9/2/25 at 5:33 p.m., resident #4 was sitting in a wheelchair in the dining room. Resident #4 would roll back from the dining room table, then roll back up to the dining room table, without assistance. During an interview on 9/3/25 at 5:07 p.m., staff member B stated she was responsible for completing the MDS assessments. Staff member B stated the facility had an interdisciplinary team meeting after resident #4's fall (on 4/10/25). Staff member B stated, When [Resident #4] returned from the hospital on 4/16/25, she was non-ambulatory, so there was nothing to change. Staff member B stated she should have done a Significant Change MDS instead of a Quarterly MDS. Staff member B stated she would look at the RAI guidelines to determine if a significant change MDS was needed. Staff member B stated the policy for MDSs is based on the RAI manual, and they do not have any other MDS policies in place.Review of resident #4's Quarterly MDS, with an ARD of 3/16/25, section GG, showed resident #4 was independent with ambulation and required supervision for toileting and transferring in and out of bed. Resident #4 showed she needed substantial assistance for dressing, bathing, and personal hygiene. Resident #4 was not coded as using a wheelchair. Section M of resident #4's MDS showed no surgical wounds, and Section J showed no fractures.A review of resident #4's Quarterly MDS, with an ARD of 6/19/25, section GG, showed resident #4 was coded for wheelchair use, and was no longer able to ambulate independently, and had become dependent on staff for transferring in and out of bed, toileting, bathing, dressing, and personal hygiene. Section J was marked as having no fractures. A record review for resident #4 showed she sustained a hip fracture due to a fall that occurred on 4/10/25, and the resident had surgery to repair the fracture. Review of a facility document titled Resident Assessment-RAI, dated 4/11/25 showed: Policy: This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences using the resident assessment instrument (RAI) specified by CMS.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to submit a Quarterly MDS (Minimum Data Set) assessment within the required time frame for 1 (#3) of 12 sampled residents. Findings include:Review of resident #3's Quarterly MDS (Minimum Data Set), with an ARD (Assessment Reference Date) of 7/11/2025, showed a completion date of 7/25/25. The assessment was not submitted and accepted until 8/19/25, 11 days past the required submission date. During an interview on 9/3/25 at 5:07 p.m., staff member B stated she was the staff member responsible for completing the MDS (Minimum Data Set). Staff member B stated she knew there were some MDS (Minimum Data Set) assessments that were late. Staff member B stated, I just have so much on my plate. I also was having to help cover shifts on the floor, so there were things (assessments) that were late. We have hired someone to help me, and that will take some tasks off my plate. Review of a facility policy titled Resident Assessment-RAI, with an implementation date of 4/11/25, showed: Policy: This facility makes a comprehensive assessment. using the resident assessment instrument (RAI) specified by CMS.Policy Explanation and Compliance Guidelines:1. The current version of the RAI (MDS 3. 0) will be utilized. In accordance with the instructions found in the RAI Manual.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to code medications accurately on the MDS assessment for 1 (#3) of 12 sampled residents. Findings include:Review of resident #3's Quarterly MDS, with an ARD of 7/11/25, showed question N0300. Injections-Record the number of days injections of any type were received during the last 7 days or since admission or reentry if less than 7 days. A 0 was marked. Section N0350. Insulin was disabled by question N0300. Section N0410, for the High-Risk Drug Classes, Use and Indication, showed, J. Hypoglycemic (including insulin), was marked No.Review of the Resident Assessment Instrument, dated October 2024, showed: . Insulin injections are counted in this item as well as in Item N0350. Record the number of days that any type of injection (e.g., subcutaneous, intramuscular, or intradermal) was received. N0415J1. Hypoglycemic (including insulin): Check if a hypoglycemic medication was taken by the resident anytime during the observation period .Review of resident #3's Physician Orders, dated 6/1/25 to 8/8/25, showed, Lantus Solostar subcutaneous pen-injector 100 unit/ML (insulin Glargine) Inject 70 units subcutaneously one time a day related to type 2 Diabetes Mellitus, and metformin oral tablet 1000 MG. Give 1000 mg by mouth two times a day related to type 2 Diabetes Mellitus. [sic]Review of resident #3's Medication Administration Record showed she received 70 units of Lantus (insulin) every morning, and 1,000 milligrams of metformin (a hypoglycemic) twice daily during the 7-day look-back period. During an interview on 9/3/25 at 5:07 p.m., staff member B stated she was responsible for the completion of the MDS assessments, and she was not sure why she had not marked insulin or hypoglycemic medication on resident # 3's MDS.Review of a facility policy titled Resident Assessment-RAI, with an implementation date of 4/11/25, showed: . 1. The current version of the RAI (MDS 3.0) will be utilized. in accordance with the instructions found in the RAI Manual.1. The assessment will include at least the following:. n. Medications.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to revise a comprehensive care plan to include behavioral health services being provided for 1 (#3) of 12 sampled residents. This deficient practice increased the risk of the resident not receiving necessary services for mental health. Findings include: During an interview on 9/4/25 at 9:04 a.m., staff member A stated she had been working as the facility Administrator, Social Worker, and Business Office Manager. Staff member A stated that resident #3 was seeing a mental health provider via tele-health services.During an interview on 9/4/25 at 11:20 a.m., staff member B stated care plans should include mental health concerns. Staff member B stated, If a resident had mental health concerns, the care plan would address the non-pharmacological interventions, as well as the pharmacological interventions, any triggers the resident may have had, and any other pertinent behavioral health information. Staff member B stated, I know that the care plans are lacking.Review of patient #3's comprehensive care plan, dated 4/15/25, showed: Focus: The resident has a mood problem r/t PTDS.Goal: The resident will have improved mood state: happier, calmer appearance, no s/sx of depression, anxiety, or sadness, through the review date.Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. [sic] Resident #3's comprehensive care plan did not show a revision addressing the resident's telehealth services provided by a mental health professional.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility staff failed to perform a thorough head-to-toe assessment, pain assessment, or transfer a resident appropriately after an unwitnessed fall with injury, which was consistent with professional standards of nursing practice, for 1 (#4) of 12 sampled residents. This deficient practice caused an increase in the resident's signs and symptoms of pain, due to a fall that resulted in a hip fracture. Findings include: During an interview on 8/28/25 at 12:24 p.m., staff member L stated she was getting ready to start laying residents down to bed when a kitchen staff member said a resident had fallen in the dining room. Staff member L stated the nurse, another staff member, and she went over to the dining room and found resident #4 lying on the floor. Staff member L stated they picked the resident up, put her in a wheelchair, then took her to her room and put her to bed. Staff member L stated that when they tried to remove resident #4's pants, she began to fight them because she was in pain and was showing signs of pain. Staff member L stated she had let staff member N know about her concerns with resident #4. Staff member L stated that staff member N told her he had been in contact with [Staff member B] and was told not to send the resident to the hospital. Staff member L stated that staff member N said if resident #4 were sent to the hospital, they would just send her back. Staff member L stated she was uncomfortable with the situation. During an interview on 9/3/25 at 5:07 p.m., staff member N stated she was notified about resident #4's fall. Staff member B stated when staff member N called her, she was notified of a hematoma on the back of #4's head, and a skin tear, but there was no mention of hip or leg pain.During an interview on 9/3/25 at 6:06 p.m., staff member N stated he was the nurse on duty the night resident #4 fell on 4/10/25. Staff member N stated he was at the nursing station when a kitchen staff member told him resident #4 fell in the dining room and was lying on the floor. Staff member N stated he walked down to the dining room and found resident #4 lying on the floor, on her side. Staff member N stated resident #4 was non-verbal and cognitively impaired. Staff member N stated he completed a quick assessment of her head and found a large bump on the back of her head, and at that time, staff member N stated he did not feel resident #4 was expressing any problems. Staff member N stated, We picked her up and put her into a wheelchair, and she started to show signs of pain, so we put her to bed and started neuro checks. Staff member N stated resident #4 did not weigh much, so a (mechanical) lift was not used to put the resident into a wheelchair. Staff member N stated he completed range of motion assessments on resident #4's upper extremities, but he did not complete an assessment on her lower extremities. Staff member N stated, Resident #4 could be combative at times, and I don't like to get hit, so I did not push it. Staff member N stated he notified resident #4's Power of Attorney and physician of the resident's fall. Staff member N stated he documented a nursing note about the incident, but had to strike it out, because it was not written in the right place in the resident's medical record, but he did not go in and write another note regarding resident #4's fall or status. Staff member N stated he could not remember if he had completed the resident's pain assessment after resident #4's fall. Staff member N stated, If I did, it would be documented in the chart.A review of resident #4's nursing notes and assessments, from 4/10/25 until 4/11/25, showed no documentation of a pain assessment following the resident's fall, completed by staff member N. A review of resident #4's nursing notes, dated 8/28/25, showed staff member B created and entered a late entry note about resident #4's fall, and this was 140 days after the incident occurred. Review of resident #4's electronic medical record, under the assessments, showed that no fall assessments were completed on resident #4, before her fall.Review of a facility document titled Provision of Quality Care, dated 4/11/25, showed: Policy: Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, . Review of a facility document titled Falls Prevention Program, dated 4/11/25, showed: . 9. When any resident experiences a fall, the facility will:a. Assess the resident.1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. 4. Qualified persons will provide the care and treatment in accordance with professional standards of practice, .

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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.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision and monitoring and ensure the safety and well-being of a cognitively impaired resident who displayed frequent wandering patterns, and the resident had an unwitnessed fall with major injury. This failure resulted in the resident being transferred to the ER, a hospitalization, a surgical procedure, and a total loss of independent ambulation for 1 (#4) of 6 residents sampled for falls; and the facility staff failed to follow the established policies and procedures. These failures were identified to be an Immediate Jeopardy situation.On 9/2/25 at 4:05 p.m., the Administrator and facility management team, including corporate staff, were notified that an Immediate Jeopardy existed in the area of F689 - Accidents and Hazards, related to the failure to provide sufficient supervision and adequate and timely response to an unwitnessed fall for resident #4. The severity and scope identified for the Immediate Jeopardy were identified to be the level of J, and upon the removal of immediacy, lowered to a G. The facility provided a plan to remove the immediacy, and this was accepted by the State Survey Agency. The facility carried out the plan, which was verified by the surveyors onsite, on 9/3/25 at 4:16 p.m.Findings include:1. Resident #4:During an observation on 8/27/25 at 4:08 p.m., resident #4 sat in a wheelchair in the hallway outside of a staff meeting room. Resident #4 attempted to push open the door to the room. Resident #4 smiled and rolled herself back in the hallway, away from the door when surveyor went to close the door to make a phone call.During an observation on 9/2/25 at 5:33 p.m., resident #4 was sitting in a wheelchair in the dining room. Resident #4 would roll back from the dining room table, then roll back up to the dining room table, without assistance. During an interview on 8/27/25 at 11:28 a.m., staff member H stated she worked the day shift the morning resident #4 was transferred out of the facility by EMS. Staff member H stated she had very little information given to her during the shift change report. Staff member H stated resident #4 had been active in the facility most days, up and walking around. Staff member H stated resident #4 seemed grumpy most of the time, and sometimes it was hard to tell how she was doing due to her mental status. Staff member H stated she entered resident #4's room and saw her in bed with her face pointing upward in a hard stare. Staff member H stated she asked resident #4 if she was hurt, when she noticed her face and saw her holding her left side. Staff member H stated she went to get assistance from staff member M to respond to resident #4. Staff member H stated staff member M called for EMS to respond to resident #4. Staff member H stated, The EMS people were here for a while before they left.During an interview on 8/28/25 at 8:02 a.m., staff member M stated she received a shift change report from staff member N the morning resident #4 was transferred from the facility by EMS. Staff member M stated staff member N told her resident #4 had a fall and was in a lot of pain. Staff member M stated she did not know what the staff did for her through the night. Staff member M stated she asked staff member N why resident #4 was not sent out to the hospital for an evaluation after the fall, and he stated staff member B told him not to send her. Staff member M stated she entered resident #4's room and saw resident #4 in bed, moving around, making facial grimaces. Staff member M stated she checked the resident in the bed and saw she was wet. Staff member M stated that with the help of other staff members, she rolled resident #4 to her side for support to change her. Staff member M stated she heard a loud sound from resident #4's left leg. Staff member M stated she could see the resident's condition and called EMS for assistance.During an interview on 8/28/25 at 12:24 p.m., staff member L stated she had been working the night shift when the event occurred with resident #4 and the fall. Staff member L stated she had been getting residents ready to put them to bed, when a kitchen worker arrived to seek nursing assistance. Staff member L stated that three staff members (including herself and staff member N), responded to the dining room to find resident #4 on the floor. Staff member L stated they moved resident #4 from the dining room floor and put her into a wheelchair. Staff member L stated they lifted the resident manually from the floor to the wheelchair, with a staff member supporting the resident under each shoulder and arm. Staff member L stated resident #4 fought the staff, pushing out at them, when they went to move her pants for the transfer. Staff member L stated the three staff members moved resident #4 to her bed using the wheelchair and manually transferring her. Staff member L stated she checked on resident #4 in bed throughout the night.During an interview on 9/2/25 at 9:14 a.m., NF3 stated he received a call from a male nurse the night of 4/10/25. NF3 stated the nurse told him resident #4 had fallen from her bed, that she might have rolled from bed. NF3 stated he asked the nurse if it was serious and if he should come over to check on her. NF3 stated the nurse told him no, that

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview and record review, the facility failed to maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the regulatory requirements, and show systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. The facility failed to implement a comprehensive QAPI plan that would sufficiently identify and correct quality concerns, and this failure may affect all residents of the facility. Findings include: During an interview on 9/4/25 at 11:20 a.m., staff member A stated the facility did not have a QAPI plan in place, but they are working on implementing one. Staff member A stated, Documentation is important, and we are trying to utilize the risk management system, but we are still seeing a lot of errors in the process. We are not getting a lot of feedback. I know we need to get more people involved, but it's so hard being so small. We are still too new. We are going to be implementing a QAPI plan we just have not done so, the template we are switching to is much better. Staff member A stated data is collected, monitored, and tracked through the risk management program, chart review, and the infection prevention binder. Staff member A stated, We complete the QAPI form and work though the form and go from there. If we notice a concern, we will start a PIP until we feel compliance is met. 1. Quality Concerns: During an interview on 9/4/25 at 11:40 a.m., staff member B stated she had not been holding regular care conferences with residents or resident representatives to ensure feedback and information would be gathered or presented to the QAPI committee for the identification of quality-of-care concerns. 2. Falls:Review of a facility document titled, Quarterly Quality Assurance meeting, dated 4/18/25, showed: . Falls-12-Have all incidents been investigated, resolved, and reported if appropriate- Yes is highlightedIdentified problem Areas/Trends eg. time of day, location, incident type:10 unwitnessed falls, 2 witnessed falls, Is a PIP indicated . and No was highlighted.This QAPI meeting occurred one week after resident #4 suffered a fall with injury, and the fall was unwitnessed, and the resident was not a reliable reporter. Review of a facility document titled, Quarterly Quality Assurance meeting, dated 7/18/25, showed 14 falls.No documentation was present on tending, tracking, root cause analysis, or the section to show if a PIP was indicated.This document also showed three urinary tract infections were present that were not present during the last QAPI meeting, but there was no documentation on the form to show this concern was addressed.3. Facility Reported Events: On 8/25/25, it was identified that the facility had no documented facility reported incidents submitted to the State Survey Agency. The facility was not able to provide any prepared or completed investigations for any facility reported events submitted to the State Survey Agency. The facility had an initial certification survey in December 2024, and a complaint survey in July 2025, and no reportable events were submitted to the State Survey Agency iduring this time. During an interview on 8/26/25 at 10:04 a.m., staff member A stated she had been working in the roles of Administrator, Social Services Designee, and Business Office Manager for the facility. Staff member A stated she was also working as the Grievance Officer and the Abuse Prevention Coordinator, for now. Staff member A stated she was not aware of issues in the facility related to quality-of-care concerns that would require reporting and investigating as a facility reported incident. Staff member A stated if a resident or family had complaints or issues, she worked to take care of them right in the moment. Staff member A stated when she worked on things, she might get caught up and not have a chance to write them down. Staff member A stated, It's not my strong point documenting things. Staff member A stated the ultimate responsibility went to her for responding to incidents and those processes. It was identified staff member A was not completing the required tasks.Record review of the QAPI program and performance plans failed to show the facility identified and actively worked to correct the concern related to lack of reporting of events to the State Survey Agency and or the investigation and follow up of events. 4. QAPI Program:Review of a facility document titled, Quality Assurance and Performance Improvement (QAPI), dated 4/11/25, showed:. Policy Explanation and Compliance Guidelines: The QAPI program includes the establishment of a QAPI committee and a written QAPI plan. 3. The QAPI plan will address the following elements:a. Design and scope of the facility's QAPI program.b. Policies and procedures for feedback, data collection systems, and monitoring. f. Process to ensure care and services delivered meet accepted standards of quality.4. The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to:a. The written QAPI Plan. b. Systems and reports demonstrating systemic identification

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to have the required members for attendance and participation in Quality Assurance and Performance Improvement (QAPI) meetings, including the Medical Director (or Designee), which were at a minimum, required to be completed quarterly. This deficient practice had the potential to affect all residents who received care in the facility. Findings include: During an interview on 9/3/25 at 5:07 p.m., staff member B stated she attended the QAPI meetings. Staff member B stated, I just show up and do what I need to do and give my input. That is all.During an interview on 9/4/25 at 11:20 a.m., staff member A stated herself, and staff member B, attend the QAPI meetings, and that sometimes staff member C joins the meeting via phone call but does not attend all the meetings. Staff member A stated Staff member G does not attend the meetings in person, but staff member G is presented with the information fromn the QAPI meeting after the fact, via a phone call. Staff member A stated, We only have [Staff member G] onsite once a month. Staff member A stated she knew they needed to add more members to the QAPI IDT, but she had not invited other staff members to attend. Review of the facility's QAPI minutes and attendance sign-in sheets, undated, showed a month where staff member A, staff member B, and staff member O attended the QAPI meeting. In April 2025, July 2025, and August 2025, the attendance sheet showed staff member A, staff member B and staff member G signed as attending. No additional facility staff were noted to be present at the QAPI meetings. No documentation was presented that showed staff member C had attended any QAPI meeting via phone. Review of a facility document titled, Quality Assurance and Performance Improvement (QAPI), dated 4/11/25, showed:. Policy Explanation and Compliance Guidelines:1. The QAPI program includes the establishment of a QAPI committee and a written QAPI plan.2. The QAPI Committee shall be interdisciplinary and shall:a. Consist at a minimum of:i. The Director of Nursing Servicesii. The Medical Director or his/her designee;iii. At least three other members of the facility's staff, at least one must be the administrator. [sic]