| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275159 | A. Building<br>B. Wing | 02/10/2026 |

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| Beartooth Rehabilitation and Nursing LLC | 350 W Pike Ave<br>Columbus, MT 59019 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to implement and operationalize a smoking policy when there were smokers residing at the facility, who were unsafe and kept their smoking materials. Residents smoked in a designated and unmonitored smoking area; one resident (#12) utilized oxygen and kept her nasal cannula and oxygen cannister in close proximity while smoking, to include using a lighter with an open flame; resident (#20) was often in proximity to resident #12 when smoking, which placed her at a higher risk of injury due to the unsafe smoking practices of resident #12. The facility did not identify and address individualized smoking safety risk factors, and care plans were not implemented with individualized safety interventions to mitigate smoking-related risks for 6 (#s 5, 12, 20, 23, 24, and 35); and failed to ensure a lighter was secured in accordance with the resident's smoking assessment and care plan for 1 (#5) of 6 residents sampled for smoking. These failures increased the risk of harm for residents who smoked, as well as others in the facility. The concerns related to unsafe smoking contributed to the Immediate Jeopardy situation announced during the survey (see below). Findings include: On 2/9/26 at 1:30 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 #12, which was identified to be at the severity and scope of J. Upon removal of the immediacy, this was lowered to an E. The facility submitted an acceptable plan to remove the immediacy, and it was verified by the State Survey Agency that the facility removed the immediacy as of 2/9/26 at 6:15 p.m. Findings include: As part of the required entrance conference materials to be submitted to the State Survey Agency, it was found during the document review(s) that the facility failed to provide an accurate list of residents who smoked. The list provided only included five resident names, not six. It was found that the facility had six residents who smoked. The list provided did not include resident #35, although a smoking safety screen had been performed for resident #35 on 7/23/25, which was two days after his admission on [DATE].<br><br>Concerns related to residents who smoke include:<br><br>1. Resident #12 - identified to be involved in the immediate jeopardy situation:<br><br>During an observation on 2/7/26 at 2:14 p.m., resident #12's door to her room was open, and she was sitting up on her bed. Resident #12 was holding crafting materials in her hands. Resident #12 was using a lighter, which had an open flame, to heat pieces of the craft materials together and there was an oxygen concentrator by the bed. Multiple storage boxes of crafting materials, fabric, and supplies were lined against a wall beside her bed. A faint smell of material burning was noticed directly outside the door to the resident's room. There was no visible sign on the door to her room to show the hazard related to oxygen equipment being present or in use in the room. The door did not have any signage displaying No smoking.<br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an observation on 2/8/26 at 3:15 p.m., resident #12 was seated in a wheelchair, wearing a nasal cannula, with a portable oxygen tank attached to the resident's wheelchair. Resident #12 was being pushed by resident #20 to go into the dining room. The doors to the dining room were closed because of a church group activity. Staff member J was standing near the dining room doors, and resident #20 asked her about going outside to smoke. Staff member J stated to residents #12 and #20 that they would have to go outside later, since the activity was going on. Resident #20 pushed resident #12 in her wheelchair down the hallway away from the dining room doors.<br><br>During an observation and interview on 2/9/26 at 8:24 a.m., resident #12 was seated in the designated smoking area outside with resident #20. Resident #12 was sitting in a wheelchair, wearing a nasal cannula, and smoking a lit cigarette; there was an oxygen cannister on the back of the resident's wheelchair. Resident #20 was sitting near resident #12 in a chair, approximately six feet away, smoking a lit cigarette. Resident #12 stated her oxygen was not turned on. Resident #12 stated, I don't want to blow myself up, the oxygen is off, see, and reached to the back of her wheelchair to twist the oxygen wrench to turn the valve closed. Resident #12 removed the nasal cannula from below her nose and lowered it to her sternum, like she was wearing a necklace. Resident #12 stated, Here, I will do this just in case, and pulled the nasal cannula tubing from around her chest to lie behind the wheelchair near the portable oxygen tank. The portable oxygen tank was held in an oxygen cylinder holder attached to her wheelchair. The oxygen pressure regulator showed a pressure reading of 800 psi in the oxygen tank.<br><br>During an interview on 2/9/26 at 8:46 a.m., staff member F stated it was not safe for resident #12 to go outside to the smoking area to smoke wearing a nasal cannula with a portable oxygen tank. Staff member F stated, I'm newer to this environment (long-term care), but I don't think it's safe to have lighters in rooms, especially residents with oxygen.<br><br>During an observation and interview on 2/9/26 at 8:54 a.m., resident #12 entered the outside smoking area with resident #20. Resident #12 had her lighter and a cigarette in her hand, with a nasal cannula in place under her nose. Resident #12 sat in her wheelchair approximately four feet away from resident #20, who sat in a chair. Resident #12 stated she had turned her oxygen tank off, lifted the nasal cannula prongs up to her mouth, and sucked air in from it. Resident #12 stated she still had air left in her oxygen tank. Resident #12 stated she had been a paramedic, so she knew how important it was not to have oxygen on when she smoked.<br><br>During an interview on 2/9/26 at 9:05 a.m., staff member A stated resident #12 had not been going outside to smoke until resident #20 started to invite resident #12 to join her to go outside to smoke. Staff member A stated that resident #12 knew not to wear her nasal cannula or use oxygen when she smoked. Staff member A stated she had started to make sure resident #12 did not go outside with oxygen on. Staff member A stated resident #12 was not to keep lighters in her room with her oxygen equipment.<br><br>Review of resident #12's smoking safety screen assessment, dated 11/26/25, showed the facility determined resident #12 was safe to smoke without supervision. The assessment showed resident #12 did not use supplemental oxygen, so the resident was not assessed to safely remove and store oxygen prior to initiating the smoking activity.<br><br>Review of a facility policy titled Resident Smoking, implemented 4/11/25, showed resident #12's written name and signature, with no date, to show when the smoking policy was explained to resident #12 by staff, or when resident #12 initially agreed to the smoking policy.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2. Resident #5:<br><br>During an observation and interview on 2/7/26 at 1:56 p.m., resident #5 stated she was a smoker and reported she kept her own smoking supplies. The resident showed the surveyor cigarettes and a lighter stored in a pouch inside her bedside dresser drawer. The lighter was accessible to the resident.<br><br>During an interview on 2/9/26 at 8:10 a.m., staff member J stated resident #5 had previously been found with marijuana and had hidden it in her room or outside. Staff member J stated resident #5's room had been searched on prior occasions.<br><br>Review of resident #5's electronic health record showed resident #5 was admitted to the facility on [DATE].<br><br>Review of the resident #5's progress notes showed multiple concerns related to marijuana use and smoking safety as follows:<br><br>-12/14/25 at 4:53 a.m., nursing progress note, .self-propels own w/c out to smoking area with staff supervision.<br><br>-12/17/25 at 10:00 a.m., social service progress note, .Resident Advocate and CNA went and spoke with resident about the marijuana. Resident denied having any more marijuana and understands the rules and regulations of the facility. Resident stated that she has ran out of it. Resident Advocate notified administrator and DON of the outcome and will continue to monitor the resident to make sure there is no more marijuana in resident's room or on resident. [sic]<br><br>-12/18/25 at 3:24 p.m., social service progress note, .Local law enforcement called as resident has been found with marijuana on the premises and was asked for it 2 days ago, but resident denied having any. Other residents in the facility reported that resident was still smoking it outside of the facility. Local law enforcement came and search residents' room and belongings with approval from resident. There was no marijuana found. Law enforcement then explained to resident about the marijuana use cannot happen at the facility as it was against facility rules and regulations and against federal law which the facility has federal funding. [sic]<br><br>-12/26/25 at 9:25 a.m., nursing progress note, Note Text: A concerned resident informed this nurse this morning that she observed [Resident #5] allegedly smoking illegal products outside this morning in addition to dropping what appeared to be Visine in her coffee. It was also reported to be by this concerned resident that staff approaching [Resident #5] outside began to question what she was doing and she lied about what she had in her possession. [sic]<br><br>-12/26/25 at 9:33 a.m., behavior progress note, Note Text: At approximately 9 am Resident Advocate was informed by another resident that resident was outside in the smoking area in the corner getting ready to smoke marijuana. Resident advocate went out another door and saw resident loading a marijuana pipe. When confronted resident lied and stated it was a cigarette. Resident then came back in the building and resident advocate in front of nursing staff asked resident for the marijuana, her pipe, and gold tin that she keeps it in. Resident denied having it and stated that she is not smoking marijuana on the premises. Resident advocate explained to resident that using marijuana along with being on morphine is dangerous and that it should not be mixed.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -1/1/26 at 9:52 a.m., nursing progress note, Note Text: Resident room had aroma of marijuana.<br><br>-1/3/26 at 2:03 p.m., nursing progress note, Note Text: Notified by staff that resident had marijuana on bedside table. Not visualized by nurse. Hospice nurse in room.<br><br>Review of resident #5's comprehensive care plan, last reviewed on 12/30/25, showed,<br><br>. Focus: At risk for injury and complications related to smoking. Date Initiated 12/15/25<br><br>Goal: Resident will smoke safely and in accordance with the smoking policy through the next review. Date Initiated 12/15/25<br><br>Interventions: If unsafe smoking practices are observed or if it is suspected that resident has violated the smoking policy, staff shall intervene immediately as needed for safety and notify administrative staff so appropriate follow up actions can be taken. Date Initiated 12/15/25<br><br>-Resident has been assessed and determined to have independent smoking privileges. Date Initiated 12/15/25<br><br>-Smoking materials (lighter) to be stored securely at the nurse's station. Date Initiated 1/20/26.<br><br>The resident's comprehensive care plan did not include an intervention requiring the lighter to be secured at the nurse's station until 1/20/26, despite the documented marijuana-related concern on 12/17/25 and multiple subsequent allegations. Additionally, on 2/7/26, the lighter remained in the resident's room and accessible, contrary to the care plan intervention initiated on 1/20/26.<br><br>Review of resident #5's Smoking Safety Screen with an effective date of 1/16/25 showed,<br><br>.C. Smoking Determination:<br><br>1. Based on the assessment, the facility has made the following determination related to resident smoking privilege status: a. Safe to smoke without supervision .<br><br>2a.Resident to keep lighter locked up at nurses station. [sic]<br><br>3. Resident #20:<br><br>During an observation and interview on 2/9/26 at 8:26 a.m., resident #20 was outside in the designated smoking area with resident #12. Resident #20 was wearing a smoking apron, holding a lit cigarette, and smoking it while seated in a chair approximately six feet away from resident #12. Resident #20 stated, I wouldn't let her hurt herself, when asked about resident #12 having a tank of oxygen on her wheelchair while wearing a nasal cannula. Resident #20 stated she and resident #12 both had their own lighters and could use them unsupervised. There was no visible signage showing that the outside area was a designated smoking area, and there was no signage with information related to no oxygen use in the smoking area.<br><br>Review of resident #20's smoking safety screen assessment, dated 1/20/26, showed the facility determined resident #20 was safe to smoke without supervision. The facility implemented a smoking apron as an intervention to ensure safety with smoking activity, due to, a tremor that worsens at<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | times, placing her at increased risk for burns.<br><br>4. Resident #23:<br><br>Review of the list of residents who currently smoke, provided by the facility on 2/7/26, showed that resident #23 was a smoker.<br><br>During an interview on 2/9/26 at 12:47 p.m., staff members D and F were present. Staff member D said resident #23 did not smoke. Staff member D said the staff removed vapes from her room. Staff member D said if anyone were going to bring her cigarettes or vapes, it would be her sister.<br><br>During an interview on 2/9/26 at 3:30 p.m., staff member F said she had seen vapes fall from resident #23's person to the floor. Staff member F said the nurses have recently taken vapes away from her, and they keep getting added to the collection in the medication room.<br><br>Review of resident #23's Minimum Data Set, dated [DATE], showed resident #23 did not smoke. Review of resident #23's care plan did not include smoking or the use of vapes.<br><br>5. Resident #24:<br><br>During an observation and interview on 2/7/25, resident #24 said he did smoke, but was allowed to be independent with his smoking. Resident #24 said it was difficult to get through the door to the smoking area because the threshold was steep, but he managed. Resident #24 said he had no issues with smoking at the facility. No smoking paraphernalia was observed during this observation.<br><br>Review of resident #24's medical record showed a resident smoking policy in his chart. The facility policy had resident #24's printed name, but no date.<br><br>Review of resident #24's smoking safety screen nurses' notes dated 1/14/26 showed resident #24 was able to safely demonstrate how to maintain the electronic cigarette according to the manufacturer's guidelines, including charging, cleaning, and storing the electronic cigarette.<br><br>During an interview on 2/9/26 at 12:47 p.m., staff member D said resident #24 was found with a vape on his heater. The vape was removed and put into the medication room. Resident #24 had not asked for the vape back, and he is only smoking cigarettes.<br><br>6. Resident #35:<br><br>During an observation and interview on 2/7/26 at 2:07 p.m., resident #35 was seated on his bed, moving tobacco materials. Resident #35 stated he was going to go outside to smoke with resident #5, who was in his room in her wheelchair. Resident #35 pulled tobacco from a bag and used paper to roll a cigarette. Several lighters and more bags of tobacco material were on resident #35's dresser next to his bed. Resident #35 stated smoking times were flexible, and smokers outside were not supervised by staff. Resident #35 stated he went outside with other residents who smoked, and stated resident #20 had to wear a smoking apron because she had burned her clothes. Resident #35 stated he thought resident #20's smoking apron was a punishment, and resident #20 should not be forced to wear it.<br><br>Review of a facility policy titled Resident Smoking, implemented 4/11/25, showed:<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents.<br><br>1. Smoking is prohibited in all areas except the designated smoking area. A Designated Smoking Area sign will be prominently posted.<br><br>2. Safety measures for the designated smoking area will include, but not limited to:<br><br>. d. Accessible fire extinguisher.e. Prohibition of oxygen use in the smoking area.f. Located 20 feet from exits in order to protect non-smoking residents from second-hand smoke.<br><br>8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with their care plan .<br><br>12. If a resident or family does not abide by the smoking policy or care plan (e.g., smoking materials are provided directly to the resident, smoking in non-smoking areas, or does not wear protective gear), the plan of care may be revised to include additional safety measures<br><br>13. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.<br><br>Review of a facility policy titled, Oxygen Administration, implemented 4/11/25, showed:<br><br>. 11. Staff shall monitor for complications associated with the use of oxygen and take precautions to prevent them. Possible risks and complications include, but are not limited to:<br><br>a. Fire .<br><br>Review of a facility policy titled Accidents and Supervision, implemented 4/11/25, showed:<br><br>. 1. Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All identifying staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on observation and interview, the facility failed to employ a certified dietary manager who provided necessary oversight to the kitchen or a full-time dietician to oversee the dietary department. This deficient practice had the potential to affect all residents who received meals and nutritional services by increasing the risk for nutritional concerns, inadequate oversight of food service operations, and compromised food quality and safety. Findings include:During an interview on 2/7/26 at 12:40 p.m., staff member O said he has been in the dietary manager position for approximately three months. Staff member O said he received an email two to three days prior, showing he had been enrolled in an education course, but said he was not currently certified. He stated he did not know who the registered dietitian was for the facility. During an interview on 2/7/26 at 1:05 p.m., staff member B informed the survey team that the facility did not currently employ a certified dietary manager.During an interview on 2/9/26 at 3:12 p.m., staff member W stated she worked at the facility on a part-time basis. Staff member W assisted with nutritional oversight for the residents. During an interview on 2/10/26 at 8:39 a.m., staff member S was asked what oversight she provided to the kitchen, and she stated she did the ordering only, and she did not provide oversight to the dietary staff or the dietary manager. Staff member S was notified that the facility was utilizing her ServSafe Food Protection Manager Certification to meet the certified dietary manager requirement. Staff member S said she was not aware she was expected to provide oversight to the kitchen and reported she was not present in the kitchen enough, and it was physically impossible to provide such oversight.Documentation was requested for staff member O's personnel file or resume to determine his prior work experience, and no documentation was provided prior to the end of the survey to verify the dietary manager certification, training, or qualifications consistent with the regulation requirements for the dietary manager. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store food, thaw potentially hazardous food, handle food for meal service, and maintain kitchen equipment in a clean and sanitary manner to prevent potential contamination and growth of bacteria. These deficient practices were observed in the dry storage area, dish room, food preparation area, and during meal service, and resulted in unsanitary conditions in the kitchen. These failures would affect any resident who received food and or services from the kitchen. Findings include:1. During the initial tour of the kitchen on 2/7/26 at 12:35 p.m., the following concerns were observed in the dry storage area:-A white paper bag label powdered sugar was open and not properly closed or covered. The bag was not dated with an open date.-A large paper bag of granulated cane sugar was opened and loosely folded at the top on a wire storage rack (not closed tightly). The bag was not dated with an open date. Granulated sugar was visibly spilled and scattered across the floor beneath the storage rack. The bag labeled cane sugar was observed to be open and not closed properly or dated with an open date.The bags were not sealed in a manner that would protect the contents from contamination, pests, or environmental exposure.2. During a follow-up visit to the kitchen on 2/9/26 at 7:40 a.m., the following were observed:-A fan was located on the wall where the clean dishes were stored and was observed with a heavy accumulation of dark colored dust, grease, grime, and debris on the fan guard, blades, and surrounding housing of the fan. The buildup was thick and visibly adhered to the metal grate and interior components. The accumulation appeared longstanding, as if it were not routinely cleaned.-The floor beneath the dishwasher had a heavy buildup of dark debris, food residue, grease-like buildup, and soiled standing material surrounding the floor drain and plumbing pipes. The floor surface was visibly soiled with blackened buildup and encrusted matter adhered around the base of the drainpipe and on the floor. The area did not appear to have been cleaned routinely. -The interior of the microwave contained visible dried food splatter on the bottom surface and along the interior walls. The glass turntable had dried residue and food particles on the surface. The inside of the microwave door and frame had dried drips and splatter from food/fluids cooked in the microwave prior. During an interview on 2/9/26 at 7:47 a.m., staff member P stated he had not cleaned the fan, the floor under the dishwasher, around the drain, or the microwave, and stated, It needs to be cleaned for sure.Review of the facility's kitchen cleaning log for February 2026 lacked information to show the cleaning of the fan in the dish room or the floor beneath and around the dishwasher.3. During an observation and interview on 2/9/26 at 7:50 a.m., two large commercially packaged tubes of ground beef and sausage were thawing on a metal rack at room temperature. The rack was located in the kitchen area and was not inside a refrigerator. Staff member O said the ground beef and sausage were on the rack to thaw. Staff member O stated the items would remain there until they were ready to be cooked. 4. During an observation on 2/9/26 at 7:37 a.m., during breakfast meal service: Staff member P was assembling the resident's breakfast trays with gloved hands. Staff member P:- Picked up a plate,-Grabbed a biscuit and tore it in half with the same gloved hand,- Picked up the ladle for the gravy,- Spooned eggs with a separate utensil,- Picked up the paper diet card,- Put the fruit cup on the tray-Placed the tray in the service window.This sequence of events happened for three trays. Staff member P did not change his gloves at any time during the tray assembly process, where he touched non-clean items and then food. Refer to F801 - Qualified Dietary Staff for concerns related to oversight of nutritional and kitchen services. Review of the facility's policy titled, Handwashing Guidelines for Dietary Employees, not dated, showed: .Compliance Guidelines:.6. Frequency of Handwashing: .b. After hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc.f. While preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.J. After engaging in any activity that may contaminate the hands.Review of the facility's policy titled, Food Safety<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Requirements, not dated, showed, Policy: .Food will also be stored, prepared, distributed, and served in accordance with professional standards for food service safety.3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage.b. Dry food storage - keep foods/beverages in a clean, dry area off the floor and clear of ceiling sprinklers, sewer/waste.4. When preparing food, staff shall take precautions in critical control points in the food preparation process to prevent, reduce, or eliminate potential hazards.a. Thawing - approved methods for thawing frozen foods include thawing in the refrigerator, submerging under cold water, thawing in a microwave oven, or as part of a continuous cooking process. Thawing at room temperature is not acceptable.6. All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination.a. Staff should follow facility procedures for dishwashing and cleaning fixed cooking equipment. |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide effective administrative oversight of day-to-day operations to ensure regulatory compliance related to abuse prevention processes, infection control, housekeeping, dietary services, and activities, for 8 (#s 9, 17, 27, 28, 29, 30, 37 and 46) of 28 sampled residents. The failures increased the risk of facility residents to experience inadequate protection from abuse, inadequate protection from communicable disease, unmet care needs, unsanitary environment, inadequate dietary services, and an ineffective activity program. Findings include:1. Inadequate abuse prevention processes:<br><br>Review of a facility-reported incident submitted to the State Survey Agency on 10/2/25 showed resident #27 was verbally mistreated by other residents in the dining room.<br><br>Review of a facility-reported incident submitted to the State Survey Agency on 1/3/26 showed that resident #28 reported inappropriate and unwanted touching by another resident.<br><br>Review of a facility-reported incident submitted to the State Survey Agency on 1/25/26 showed resident #37 reported inappropriate and unwanted touching by another resident.<br><br>Review of facility-reported incidents submitted to the State Survey Agency on 10/24/25, two incidents on 11/1/25, 12/3/25, and 12/6/25 showed resident #46 eloped from the facility on five separate occasions without the necessary resident-specific interventions, monitoring, or oversight put into place to prevent ongoing elopements.<br><br>During an interview on 2/8/26 at 2:12 p.m., staff member A stated she was responsible for the initial abuse and neglect reporting and the submission of these, along with the investigation findings, to BOUNDS, the electronic abuse reporting system. Staff member A stated she did not recall why the abuse reports were reported late for the identified facility reported events that occurred on 1/3/26 and 1/25/26 for residents #28 and #37.<br><br>During an interview on 2/8/26 at 3:25 p.m., staff member A stated she had instructed the staff not to document resident #17's behaviors as sexual behaviors, and to only document behaviors in the electronic medical record and care plan. This occurred after two incidents where resident #17 was reported to have touched residents #28 and #37 in a sexually inappropriate manner.<br><br>During an interview on 2/8/26 at 3:45 p.m., staff member B stated that the three final investigation reports related to resident #46's elopements were submitted late.<br><br>During an interview on 2/10/26 at 11:08 a.m., staff member A stated the investigation findings were turned in late for the facility reported incident regarding resident #27 because staff member A was working as a cook in the kitchen during that time, to cover the immediate staffing need.<br><br>2. Inadequate protection from communicable disease:<br><br>During an interview on 2/9/26 at 9:55 a.m., staff member A stated she did not know if TB screening was occurring for newly hired employees, and referred to the screenings as the nurses' responsibility, while also acknowledging that she was ultimately responsible and had not developed a system with the DON or infection control nurse to document, administer, or track pre-employment TB screening.<br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Staff member A failed to provide necessary oversight to ensure the nursing staff understood their responsibilities pertaining to pre-employment TB screening, and failed to ensure all pre-employment requirements were completed for all new employees, placing residents and staff at elevated risk for communicable disease exposure.<br><br>3. Unmet care needs:<br><br>During an interview on 2/9/26 at 3:25 p.m., staff member A stated resident #30's appointments were missed because they were scheduled during a time when the facility did not have a van or driver. Staff member A stated, I guess it slipped my mind to reschedule the appointments once the van was operational.<br><br>During an interview on 2/9/26 at 4:20 p.m., resident #30 stated he had missed two appointments in the past month as staff member A dropped the ball. Resident #30 stated he also asked staff member A multiple times over the past month to address the inconsistent and infrequent room cleaning, without any improvement noted.<br><br>During an interview on 2/10/26 at 9:01 a.m., staff member D stated she had discussed concerns within the facility repeatedly to staff member A, and staff member A would respond and say, This is the first I am hearing about this. Staff member D stated, We told her no, we have all been telling you these things for months! Staff member D stated, We run out of food, supplies, and toiletries on a regular basis. Staff member D (displaying she was exasperated) stated, It's so bad! There was an incident recently where she (staff member A) was supposed to pick up a resident from their appointment and said she would pick up supplies on her way, but she never picked up the resident, and she didn't return to the facility that day or pick up supplies! The medical office was calling the facility to have the resident picked up, and no one could reach her! Another staff person ended up running over there to pick up the resident.<br><br>During an interview on 2/10/26 at 9:29 a.m., staff member F stated, The admin (Administrator) here really isn't involved at all. She forgot to tell us recently that a new resident was being admitted . When the resident arrived, it was a surprise, and we did not have the necessary supplies to care for them. We tried to call her, but she doesn't answer her phone after hours. On the rare occasion she does have to come in, she is very angry and yelling at everyone. Everyone tiptoes around her here. I have never seen anything like it.<br><br>The facility Administrator failed to ensure day-to-day operations were performed effectively, including appointment scheduling, transportation arrangements, supply ordering, staff communication and supervision, and ensuring resident care needs were met.<br><br>4. Unsanitary environment:<br><br>During observations on all days of the survey, residents #9 and #29 had floors that were unclean. Residents #9 and #29 said housekeeping did not move furniture and or clean their rooms thoroughly. rooms [ROOM NUMBERS] were observed to have heavy, dark brownish-black, greasy stains on the threshold into the room and on the floor under the hinge side of the door. Both rooms had garbage and food debris on the floors.<br><br>During an interview on 2/7/26 at 2:33 p.m., resident #9 said, I hardly ever get to see [Staff member A]. As long as she gets people in here, that's all she cares about. I never see [Staff member A] to tell<br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | her about the problems with the rooms or with activities. Resident #9 said it made her feel bad that her room was dirty, and she felt worse because her son was upset over the dirty room.<br><br>During an interview and observation on 2/7/26 at 1:56 p.m., resident #29 complained about her room being dirty. Resident #29 said it bothered her that the housekeepers never moved anything to sweep and mop the whole room.<br><br>During an interview on 2/10/26 at 9:19 a.m., staff member A said the facility had recently experienced some census growth (increase in resident number) but had not made changes to the housekeeping department to meet that need and ensure the facility was clean. Staff member A said the facility . will start recruitment to adjust to the census. Staff member A failed to ensure the facility had the necessary number of staff available and working when the census increased, to provide care and services as needed.<br><br>5. Lack of Oversight of Kitchen, Nutritional Services, and Certified Dietary Manager:<br><br>During an interview on 2/10/26 at 8:39 a.m., staff member S was asked about the level of oversight she provided to the kitchen, and she stated she did the ordering only, and she did not provide oversight to the dietary staff or the manager. Staff member S was notified that the facility was utilizing her ServSafe Food Protection Manager Certification to meet the certified dietary manager requirement. Staff member S said she was not aware she was expected to provide oversight and reported she was not present in the kitchen enough, and it was physically impossible to provide such oversight.<br><br>The facility did not have a Certified Dietary Manager (CDM) or Dietitian in place who was sufficiently supporting the uncertified CDM or oversight to the dietary services. Multiple concerns were identified during the survey related to the kitchen, staff, and nutritional services. Refer to F801 - Qualified Staff and F812 - Food Procurement, Storage, Preparation, Handling, and the concerns were not addressed by staff member A to ensure quality deficient practices did not occur.<br><br>6. Lack of Activities/Program:<br><br>During an interview on 2/7/26 at 1:56 p.m., resident #29 said she didn't like what the facility had for activities, so she just stayed in her room and read her books.<br><br>During an interview on 2/10/26 at 9:19 a.m., staff member A said she was not surprised the residents complained about the activities. She stated the activity director just started in December (2025) and, She tries. During the transition of the new Activity Director, staff membe A failed to ensure person-centered activities were provided to meet the needs of the residents residing in the facility/<br><br>Review of a facility policy titled, Administration of Facility, dated 7/1/25, showed:<br><br>. This facility will provide policies and systems to ensure that it is administered in a manner that will focus on attaining and maintaining the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>6. An appropriately licensed Administrator, in good standing with the state in which the facility resides, will be appointed by the governing body to be responsible for the management and overall operation of the facility.<br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of a facility policy titled, Administrator-Job Description, undated, showed:<br><br>Major Duties and Responsibilities .Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations.<br><br>Cross reference F584, F600, F609, F610, F679, F689, F801, F812, F838, F847, F865, F880 |

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| F 0837<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.<br><br>Based on interview and record review, the facility's governing body failed to ensure necessary oversight was provided for the identification and correction of quality deficient practices directly involving staff member A and oversight of the facility's systems and services. The facility had two consecutive surveys with findings of Immediate Jeopardy in the areas of F689 - Accidents and Hazards, and multiple deficiencies were identified directly involving staff member A's failures to take necessary or appropriate action on a concern. This deficient practice placed residents in the facility at continued risk of their needs not being met related to safety, care, and services provided. Findings include:The previous Complaint survey, exit date 9/4/25, resulted in a finding of Immediate Jeopardy at a J in the area of F689 - Accidents and Hazards pertaining to a resident with serious major injury from a fall and a finding of G in the area of F600 - Abuse and Neglect pertaining to neglect of a resident with a serious major injury. The facility is actively in the monitoring stages of the plan of correction for audits to be reviewed by QAPI for substantial compliance to be achieved, for F689 at a J with immediacy removed to G, and F600 at a G; with 3/4/26 as the 180th day to achieve substantial compliance. The current recertification survey is the first for the facility, as its initial certification survey had an exit date of 12/5/24. The current findings of Immediate Jeopardy in the area of F689 - Accidents and Hazards pertaining to residents who smoke and use oxygen, along with F600 Abuse and Neglect findings result in a survey with second consecutive Immediate Jeopardy findings for the facility.During an interview on 2/9/26 at 9:05 a.m., staff member A stated she was not aware resident #12 was outside smoking with her nasal cannula and oxygen on. Staff member A stated resident #12 had not been going outside to smoke, until more recently when she was invited by another resident. Staff member A stated resident #12 knew not to wear her nasal cannula or use oxygen when she smoked. Staff member A stated she had started to make sure resident #12 did not go outside with oxygen on. Staff member A stated resident #12 was not to keep lighters in her room with her oxygen equipment being used. Staff member A stated the residents who smoked were all independent smokers, so there was not a routine need to monitor them as there would have been for supervised smokers.During an interview on 2/10/26 at 8:30 a.m., staff member N stated he and regional staff members B and C were part of the governing body that provided oversight to staff member A and QAPI. Staff member N stated the governing body members listed on the facility assessment were the company owners. Staff member N stated the facility assessment needed to be revised because the owners were not called in to review QAPI or provide direct administrative oversight. Staff member N stated staff member A asked for assistance and review of the facility assessment. Staff member N stated staff member A failed to complete a QAPI review for the current facility assessment. Staff member N stated staff members B and C would conduct facility site visits periodically and would relay concerns related to QAPI or issues to him for review. Staff member N stated staff members B and C would send him routine and monthly emails on areas of concern or for the review of flagged areas of concern Staff member N stated he was in the facility at times during the last six months and would do rounds in the building, but did not sign off on what he had done. Staff member N stated there was no documentation or signatures of his oversight reviews, to include those for staff member A. Staff member N stated a binding arbitration should be offered in a resident admissions agreement, and the facility had three signed binding arbitration agreements in effect right now. Staff member N stated he was aware of the current concerns related to smoking and resident access to cigarettes and lighters around oxygen. Staff member N stated smoking assessments would continue to be done quarterly, and when there was a significant change. Staff member N stated that facility staff were reestablishing systems currently in place but not being followed. Staff member N stated the facility understood it was important to have safety in place for residents who smoke, and staff would be<br>(continued on next page) |

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| F 0837<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | reminded on processes with the identified resident being moved to supervised smoking.During an interview on 2/10/26 at 12:42 p.m., staff member C stated she still oversaw the facility as a regional consultant, but she had been busy with [Facility Name] for its upcoming special focus survey, so the facility was being attended by staff member B for the current survey. Staff member C stated she did come onsite to conduct visits and review things with staff member A. Staff member C stated she had been coming in since November (2025) to monitor any plan of correction audits, from the prior survey. Staff member C stated she knew staff member A had been working on a lot of things for the last few months. Review of a facility policy titled, Administration of Facility, dated 7/1/25, showed: . This facility will provide policies and systems to ensure that it is administered in a manner that will focus on attaining and maintaining the highest practicable physical, mental and psychosocial well-being of each resident.6. An appropriately licensed Administrator, in good standing with the state in which the facility resides, will be appointed by the governing body to be responsible for the management and overall operation of the facility.7. The facility must have a governing body that is legally responsible for establishing and implementing policies regarding management and operation of the facility as well as QAPI. [sic] |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>Based on interview and record review, the facility failed to accurately complete a facility assessment and failed to identify 1 resident (#46) of 1 resident sampled for care needs. The failure resulted in elevated risk for resident needs not to be accurately and safely met. Finding include:Review of the facility assessment completed on 8/1/25 showed residents requiring hemodialysis would be transported to an outside facility. The assessment also showed Individuals who present (as) an elopement risk that cannot be safely managed with a Wander Guard system will not be admitted .During an interview on 2/9/26 at 5:30 p.m., staff member A said she was not sure whose facility assessment was in the facility folder. Staff member A said that if you look at the assessment, it might say the name of a different facility owned by the parent company. When asked about why the facility admitted a resident who was a known elopement risk, when the resident assessment identified the elopement risk prior to the resident's admission, and staff member A was unable to provide an explanation for why the facility assessment was not upheld for safety of the resident. During an interview on 2/10/26 at 8:30 a.m., staff member N said he was the governing body with the help of the regional nurses, but the facility assessment showed two different (male) names listed as the governing body. Staff member N said he assisted in writing and reviewing the facility assessment. Staff member N said he felt the environment at the facility was better for resident #46, as she might be less likely to wander. Staff member N said a location in a dry county, more female staff, and less drug seeking would be good for resident #46. Staff member N said he would revise the facility assessment to identify a siren guard alarm, as the facility does not have a Wander Guard system. Staff member N said the administrator made some minor changes the day prior to the facility assessment (2/9/26). Staff member N said the administrator and the director of nursing needed to review and update some clinical areas to correct the facility assessment. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective QAPI program that identified quality-deficient practices for corrections to needing to be made. There was no documentation or evidence of an ongoing comprehensive quality assurance program. The failure resulted in residents not being monitored for accidents and safety concerns related to smoking, and other system concerns identified during the survey, and administration was aware of the concerns, but appropriate action was not taken to implement a plan to correct them. Findings include:During a Quality Assurance Performance Improvement (QAPI) observation and interview on 2/10/26 at 9:19 a.m., staff member A stated the QAPI team had met monthly and had started to initiate performance improvement plans for areas of concern. Staff member A stated the facility had not initiated any improvement plans related to smoking because smoking had not been an issue. Staff member A said the medical director comes to the QAPI meeting quarterly. Staff member A said information from the monthly QAPI meetings would be taken to the medical director if he needed to know about any issues. Staff member A said the QAPI binder, which held the QAPI information, had been dropped and was unorganized. A large binder was observed on staff member A's desk. There was approximately half a [NAME] of paper sticking out of the binder, but the administrator said she would have to go through it to find QAPI audits and monitoring of their performance improvement plans. Staff member A said the facility had ongoing performance improvement plans for accidents and safety. Record review of a facility performance improvement plan dated 12/8/25 showed the facility initiated a plan to prevent resident #46 from eloping. Audits showing when vendors were at the facility started on 12/8/25. Review of resident #46's nurse progress notes showed resident #46 was discharged on 12/7/2025. During an interview on 2/10/26 at 8:31 a.m., staff member N identified himself as the governing board of the facility. The facility was unable to provide any evidence that staff member N had reviewed the QAPI minutes or added additional information for the facility to update or change their monitoring processes. Staff member N said the regional nurses perform visits to the facility and relay any resident care concerns to the QAPI team for monitoring. Staff member N said he does not document the meeting minute reviews he completed for QAPI, but he has been in the facility in the last six months. Staff member N said that as the [NAME] President of Operations the QAPI and overall facility management were his responsibility. Review of deficiencies cited on the survey in September 2025 showed that ongoing quality assurance monitoring should have been initiated and ongoing for resident safety. The facility failed to ensure the residents were provided supervision and an environment free from accidents and hazards. During this survey, resident #46 eloped 5 times in 43 days, and resident #12 was observed smoking while wearing oxygen, and the staff was aware of it. She also had a lighter in the room that she used, with an open flame, and there was oxygen in her room. The faclity did not have a smoking policy in place that was operationalized, and did not implement corrections for the smoking concerns. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>Based on interview and record review, the facility failed to implement an infection prevention and control program which ensured pre-employment TB screening was completed upon hire in accordance with facility policy and nationally recognized standards. The failure placed residents at elevated risk for exposure to communicable disease. Findings include:During an interview on 2/9/26 at 9:55 a.m., staff member A stated the DON's role reported directly to her in the facility chain of command. Staff member A stated she did not know if TB screening was occurring for newly hired employees, stating, That (pre-employment TB screening) is on the nurses to do. You would have to talk to the DON about that. Well, I guess that would fall back on me if the nurses don't TB screen the new hires. We really don't have a system for that. At the other facility I worked at, they would just tell me when it's done. I don't really know if anyone has gotten one (pre-employment TB screening) here since we opened, I guess that's my bad. During an interview on 2/9/26 at 2:23 p.m., staff member E stated pre-employment TB screening had not been performed prior to the survey period on 2/7/26. Staff member E stated the facility did not have a previous system to monitor or track the status of employee TB screening. Staff member E stated she initiated a spreadsheet on 2/7/26, following a surveyor's request for documentation. Staff member E stated a 2/7/26, review of employee records identified some employees had screening completed at locations which were not verified by the facility or with previous employers. Other employees underwent TB screening on 2/7/26, after the identification of missing screenings. Staff member E stated she planned to implement a pre-employment screening protocol in accordance with facility policy.During an interview on 2/9/26 at 2:26 p.m., staff member D stated, I did not know I was supposed to be doing the new employee TB tests. I was not given the tools I needed for that position. [Staff member A] never told me that (employee TB screening) was my responsibility. We (the nurses) do the new residents' TB tests, but never for the employees. Review of a facility provided document, untitled and not dated, showed a list of 39 employee names. A column titled PPD showed 6 employees received TB screening within the past year at unidentified locations outside of the facility, 15 employees received TB screening on 2/7/26 following the surveyor's request for documentation of screening, and 18 employees had no indication of TB testing. Review of a facility provided document titled, Facility Assessment, dated 8/1/25, showed, The facility maintains an aggressive infection prevention and control program under the direction of the Director of Nursing. The program includes . policies and procedures based on CDC guidance.Review of a facility policy titled, Employee Tuberculosis Testing, dated 6/11/25, showed, Tuberculosis (TB) screening and testing is conducted in this facility. Follow state or local requirements. In the absence of state or local requirements, follow CDC recommendations. At the time of employment, all new staff shall undergo pre-placement screening for TB. Review of a facility policy titled, Infection Prevention and Control Program, dated 4/11/25, showed, This facility has established and maintains an infection prevention and control program. Direct care staff shall be tested for TB upon hire. Review of a facility document titled, Facility Assessment, dated 8/1/25, showed:, . Part 2: Services and Care We Offer Based on our Residents' Needs . 2.1 Resident Support and Care Needs . Infection Prevention & Control: Identification and containment of infections, prevention of infections. [sic]Review of online CDC guidance at cdc.gov/tb, accessed on 2/17/26, showed All U.S. health care personnel should be screened for tuberculosis (TB) upon hire (i.e., preplacement). This process includes a risk assessment, symptom evaluation, and TB blood test or TB skin test. The facility failed to assess TB risks, obtain symptom evaluation, and TB blood test or TB skin test (PPD) upon hire. |

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| | 275159 | A. Building<br>B. Wing | 02/10/2026 |

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| Beartooth Rehabilitation and Nursing LLC | 350 W Pike Ave<br>Columbus, MT 59019 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observation, record review, and interview, the facility failed to maintain a clean, comfortable, and homelike environment for 2 (#s 9 and 29) of 30 sampled residents, and may affect others who were bothered by the lack of services. Findings include:During the initial facility tour on 2/7/26 between 1:00 p.m. and 2:18 p.m., the door thresholds were soiled with dark brown to black greasy looking material for rooms 206, 209, 311 and 314. During an interview and observation on 2/7/26 at 1:58 p.m., resident #29 said she had never had the furniture in her room moved for her room to be deep cleaned. Resident #29 said there is only one housekeeper per day, and she tries to get the toilets cleaned every day. Resident #29 said that when the housekeeper takes her days off, there isn't a housekeeper. Resident #29 said sometimes the housekeeper is pulled to laundry. Resident #29 said if she wants her garbage emptied, she sets it outside the door, the same way with laundry. Observations showed a yellow and orange spot on the right side of the toilet. The area around the recliner was littered with popcorn and brown dirt particles. The area around the front legs of resident #29's dresser was soiled with a brown, sticky, greasy-looking substance and had white and brown crumbs. A plastic cap was observed under the overbed table near resident #29's recliner. Observed under the recliner was a paper measuring approximately 2 inches by 3 inches and an open alcohol pad. The areas around the door frames and under the hinges were soiled with a dark brown, greasy-looking debris.During interview and observation on 2/7/2026 at 2:39 p.m., resident #9 said housekeeping does not come and get the trash. Resident #9 said sometimes the garbage was out by the door. Resident #9 said housekeeping does not clean under the furniture; they only sweep and mop in the middle of the floor. Resident #9 said she had Febreze fabric spray for freshness. Resident #9 said her dirty room bothers her. Resident #9 said it really makes her feel bad because the dirty environment bothers her son even more. Observations showed a bandage wrapper and paper on the floor by the sink. Resident #9 ran her finger over her dresser and showed the dust on the top. Resident #9's dresser and 5-tier black shelf were covered in dust. The floor by the bed and the nightstand were soiled with white, brown, and black crumbs. There was a brown dried water stain near the stand the plants were on. This stain was near the door to the room. The floor near the door hinges was heavily soiled with a brown and black, greasy substance.Observations in the facility hallways on 2/8/26 at 2:04 p.m. showed live insects crawling down the 200-wing hallway.During an observation on 2/9/26 at 7:14 a.m., live insects were observed crawling in the 100-wing hallway.During an observation and interview on 2/9/26 at 2:50 p.m., resident #29 said the housekeeper had not been in to do any special cleaning. The observations were unchanged from 2/7/26. Observations showed a yellow and orange spot on the right side of the toilet. The area around the recliner was littered with popcorn and brown dirt particles. The area around the front legs of resident #29's dresser was soiled with a brown, sticky, greasy-looking substance, and there were white and brown crumbs. A plastic cap was observed under the overbed table near resident #29's recliner. Observed under the recliner was a paper measuring approximately 2 inches by 3 inches and an open alcohol pad. The areas around the door frames and under the hinges were soiled with a dark brown, greasy-looking debris.During an observation and interview on 2/9/26 at 3:00 p.m., with resident #9, the appearance of the room was unchanged. Resident #9 said she had to put her garbage outside her door on 2/8/26. The bandage and paper were still on the floor by the sink. The white, brown, and black crumbs were on the floor by the nightstand. The brown, dried water stain appeared on the floor near the door. The dust was still on the shelves and the dresser. The floor under the door by the hinges was heavily soiled with a brownish-black substance.During an interview on 2/10/26 at 11:30 a.m., staff member I said the facility completed two deep cleans on resident rooms daily. The furniture was moved, and everything was cleaned. Staff member I said there was another housekeeper, and they tried to stay on schedule with the deep cleans. The following information was shown on the housekeeping task logs, provided<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | by the facility:-1/30/26: The log showed that no resident rooms were cleaned, and the housekeeper performed laundry tasks. -2/1/26: The log showed eight rooms received basic cleaning, and the housekeeper was reassigned to laundry for the remainder of the shift. -2/4/26: The 100 and 300 wing rooms were provided basic cleaning.-2/5/26: The occupied facility rooms had basic cleaning, including dusting, toilets cleaned, trash removed, and the floors were swept and mopped. No deep cleaning occurred. -2/6/26: The housekeeper passed paper towels and sacks to the 100 and 200 hallways, and no cleaning was documented for those wings. The rooms in the 300 hallways were dusted, the toilets cleaned, the trash was removed, and the floor was swept and mopped. At 2:30 p.m., the housekeeper was reassigned to laundry for the remainder of the shift.The cleaning logs provided showed that no resident room deep cleaning was completed, and there were numerous days when housekeeping services were not provided in January 2026. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on observation, interview, and record review, the facility failed to protect residents from inappropriate physical contact between residents for 3 (#s 17, 28, and 37), failed to ensure a resident was free from verbal abuse by a staff member for 1 (#42) and failed to ensure a resident was free from neglect related to elopements for 1 (#46) of 7 residents sampled for abuse. With each elopement, the facility neglected to address it thoroughly for future prevention, thus continuing the risk of elopement and harm. Findings include:1. Review of a facility-reported incident submitted to the State Survey Agency on 1/3/26 showed documentation of inappropriate physical contact between resident #17 and resident #28.<br><br>During an observation and interview on 2/7/26 at 1:15 p.m., resident #17 was in a wheelchair in his room and called out, Hey! On approach, he reached out and cupped the surveyor's hand with both his hands. Resident #17 was able to say Hey, Yeah, and No, throughout the interview. When asked about the incident on 1/3/26, resident #17 said. Yeah, and showed his fists to demonstrate punching, and then demonstrated pushing away of hands. When asked if he had any further contact with the individual involved in that event, and he said, No!<br><br>During an interview on 2/7/26 at 2:22 p.m., resident #28 stated, Yeah, that guy groped at me. I pushed him away. He isn't right, but I am not going to let him get away with that! . I haven't seen him since.<br><br>During an interview on 2/8/26 at 3:25 p.m., staff member A stated resident #17 has some history with (personal space and body) boundaries and stated, I told him he can't touch people and taught him to fist-bump because he especially likes to touch the ladies. Once he starts touching, that is when things escalate for him. None of the residents (involved in the events) could recall any incident, so we did not substantiate the abuse. I have told the staff not to write sexual behaviors in the (resident's) chart and just call them behaviors.<br><br>Review of resident #17's SBAR note dated 1/3/26 showed, Notified by a resident that (Resident #17) inappropriately touched her bottom . Resident continually seeks out females attempting to touch or kiss. Has been seen groping (him)self while looking into female residents' rooms . [sic]<br><br>Review of resident #17's care plan failed to show documentation specific to sexual behaviors or lack of physical boundaries with females, and there were no interventions addressing the risk for ongoing inappropriate physical contact with females before or after the 1/3/26 incident. The lack of interventions to address the sexual behaviors did not allow staff the opportunity to intervene appropriately when the resident was exhibiting the sexual behaviors.<br><br>Review of the facility's investigation of the 1/3/26 incident showed, Attempted interview on 1/05/2026. [Resident #28] could not recall the incident on Saturday attempted interview on 1/05/2026 [Resident #17] could not remember what happened Saturday . Staff spoke with [Resident #17] about keeping his hands to himself and to not touch . [Resident #17's last name] has a BIMS of 3 & [Resident #28's last name] has a BIMS of 0 Neither resident could recall an incident unable to substantiate . [sic] A BIMS score of 0 or 3 reflects severe cognitive impairment. The facility failed to identify potential abusive behaviors and anticipate resident #17's behavior or needs, and failed to implement appropriate interventions to protect other residents or resident #17.<br><br>2. Review of a facility-reported incident submitted to the State Survey Agency on 1/25/26 showed<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | documentation of inappropriate physical contact between resident #17 and resident #37.<br><br>During an interview on 2/7/26 at 4:04 p.m., resident #37 could not recall any conflicts or incidents with another resident.<br><br>During an interview on 2/9/26 at 3:12 p.m., staff member B stated, He (#17) bumped her (#37) thigh, and she got mad; that's all.<br><br>Review of resident #17's SBAR note dated 1/25/26 showed, Resident has had increased sexual behaviors. Is there anything we could give him? .<br><br>Review of resident #17's primary care physician progress note, dated 1/27/26, showed, Staff does note that he seems to be a little disruptive with his behaviors, some of them being somewhat sexual.<br><br>Review of resident #17's care plan failed to show documentation specific to sexual behaviors toward resident #37 or protective measures implemented, before or after the 1/25/26 incident.<br><br>Review of the facility's investigation of the 1/25/26 incident showed, Interview attempted on 1/25/2026 when admin got to facility [Resident #37] when asked can you tell me what happened in the dining room she said nothing happened [Resident #17's last name] interviewed and could not recall . Residents where separated, [Resident #17] was talked to by admin to keep his hands to himself. SBAR sent to the provider for medication review. Referral made to [mental health provider] . unable to substantiate. [sic] The facility did not show how the resident's cognitive impairments hindered his ability to understand discussions or any education related to the sexual behaviors.<br><br>Review of a facility policy titled Abuse, Neglect and Exploitation, dated 4/11/25, showed, . 'Sexual Abuse' is non-consensual sexual contact of any type with a resident.<br><br>The facility failed to substantiate sexual abuse for the residents involved, while simultaneously documenting #17's sexual behaviors and telling the resident to keep his hands to himself, without consideration of his cognitive impairments hindering his decisions, and staff failed to anticipate his needs.<br><br>3. Review of a facility-reported incident, dated 10/30/25 at approximately 6:30 a.m., documented an allegation during shift change wherein a staff member told resident #42, I wish you would shut the f k (profanity) up.<br><br>Review of the facility's investigative report for the event on 10/30/25 showed the allegation was substantiated. Documentation further reflected that the facility conducted interviews with staff and residents and concluded the statement was made to resident #42 as it was alleged.<br><br>During an interview on 2/10/26 at 8:08 a.m., staff member D said she was aware of the incident regarding verbal abuse involving resident #42, and stated concerns had been raised regarding the staff member involved and interactions with other residents.<br><br>During an interview on 2/10/26 at 11:34 a.m., staff member A stated the allegation (for resident #42) was received through a grievance and was reported to the State Survey Agency. Staff member A affirmed that the statement was made. Staff member A further stated that interviews conducted during the investigation identified additional reports describing the alleged staff member as rude and (continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | making residents feel small. Staff member A said the staff member's employment was terminated following the substantiated findings.<br><br>The facility substantiated that the staff member directed profane and demeaning language toward resident #42. The use of such language was identified as verbal abuse, and facility failed to ensure resident #42 was free from abuse.<br><br>4. Review of a facility-reported incidents, dated 10/24/25, 11/1/25 at 10:20, 11/1/25 at 5:40 p.m., 12/3/25, and 12/6/25 showed resident #46 had left the facility five times in 43 days. During all five of resident #46's elopements, the facility was not aware she was missing. Resident #46 was found in the community, showing that the facility neglected to put effective plans in place to prevent further elopements. During one elopement, the resident was found approximately one mile away at a busy stop near the interstate.<br><br>During an interview on 2/7/26 at 4:10 p.m., staff member J said Resident #46 was admitted to the facility after being discharged by a sister facility. Staff member J said resident #46 left the sister facility to go to a park where she would exchange sex for drugs. Staff member J said resident #46 had a history of being exploited for sex and drugs.<br><br>Review of the facility's policy titled, Abuse, Neglect and Exploitation, implemented on 4/11/25, showed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. [sic] |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on observation, interview and record review, the facility failed to ensure the resident's care plan was reviewed and revised by an interdisciplinary team when a resident had a change in condition for 1 (#4); failed to ensure the resident representative was involved in the care planning process or invite the resident's representative to care plan meetings for 1 (#8) of 30 sampled residents, and failed to ensure a resident-centered care plan was updated to include information about oxygen and safety precautions for 2 (#s 12 and 20) of 6 residents sampled for smoking. These deficient practices limited the staff's ability to perform care and communicate effectively, limited the resident representative's involvement in treatment and care decisions, and posed hazards related to unsafe smoking for residents. Findings include:1. During an observation and interview on 2/8/26 at 2:43 p.m., NF3 said resident #4 uses her cell phone to type messages. NF3 said the staff can usually communicate and understand her messages. During the interview, resident #4 was observed texting on her cell phone.<br><br>During an interview on 2/9/26 at 10:30 a.m., staff member D said resident #4 communicated with her phone by holding the phone with one hand and typing in the text message with one finger. Staff member D said resident #4 also had a magnetic board to communicate but used the phone most of the time.<br><br>During an interview on 2/10/26 at 10:58 a.m., staff member B said the resident care plans were completed and updated by the director of nursing, the assistant director of nursing, and the infection preventionist. Staff member B said the regional nurses updated care plans as necessary.<br><br>Review of resident #4's current care plan failed to identify and direct staff on how to communicate with resident #4 by using the cell phone.<br><br>2. During an interview on 2/8/26 at 11:09 a.m., NF5 stated he had not participated in care planning for [Resident #8] and had not been invited to a care plan meeting and had not attended a care plan meeting either in person or by phone since the resident's admission.<br><br>During an interview on 2/10/26 at 8:34 a.m., staff member E stated family involvement in the care plan process was multifactorial and included participation during care plan meetings, phone calls, or when family members were present in the building. Staff member E said staff member J was responsible for inviting residents and representatives to care plan meetings.<br><br>3. During an observation on 2/7/26 at 2:14 p.m., resident #12's door to her room was open, and she was sitting up on a bed. Resident #12 was holding crafting materials in her hands. Resident #12 was using a lighter with an open flame to hold or heat the pieces of the craft materials together. Multiple storage boxes of crafting materials, fabric, and supplies were lined against a wall beside her bed. A faint smell of material burning was noticed directly outside the door to resident #12's room. There was no visible sign on the door to the resident's room to indicate that oxygen equipment was present or in use. The door did not have any signage displaying no smoking.<br><br>During an observation and interview on 2/9/26 at 8:24 a.m., resident #12 was sitting in the designated smoking area outside with another resident. Resident #12 was sitting in a wheelchair, smoking a lit cigarette. Resident #12 had on a nasal cannula, which was connected to a portable oxygen tank. Resident #12 stated her oxygen was not turned on.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of resident #12's smoking safety screen assessment, dated 11/26/25, showed that resident #12 did not use supplemental oxygen, so she was not assessed to safely remove and store oxygen prior to initiating smoking activity.<br><br>Review of resident #12's comprehensive care plan showed the following two problems:<br><br>.The resident has oxygen therapy r/t COPD and Ineffective gas exchange Date Initiated: 01/22/2026, and At risk for injury and complications related to smoking. Date Initiated: 11/26/2025, with a goal of, Resident will smoke safely and in accordance with the smoking policy through next review. [sic]<br><br>The two problems listed in resident #12's care plan did not include interventions to address the hazard of oxygen use and smoking at the same time, or the use of lighters in her room for crafting in the presence of oxygen.<br><br>4. During an observation and interview on 2/9/26 at 8:24 a.m., resident #20 was seated in the designated smoking area outside. Resident #20 was wearing a smoking apron, holding a lit cigarette, and smoking it while sitting in a chair approximately six feet away from another resident who had an oxygen cannister on her wheelchair.<br><br>During an interview on 2/10/26 at 10:58 a.m., staff member B stated the director of nursing, the assistant director of nursing, and the infection preventionist were responsible for updating care plans.<br><br>Review of resident #20's smoking safety screen assessment, dated 1/20/26, showed the facility determined resident #20 was safe to smoke without supervision. The facility implemented a smoking apron as an intervention to ensure safety with the smoking activity, due to, a tremor that worsens at times, placing her at increased risk for burns.<br><br>Review of resident #20's comprehensive care plan showed a problem revised on 1/11/26, which included:<br><br>. At risk for injury and complications related to smoking. Independent per assessment and observation. Resident holds own materials. The care plan was not updated to include the intervention of a smoking apron to be used to ensure safety with smoking, although a smoking safety assessment had been completed on 1/20/26, with the addition of a smoking apron.<br><br>Review of a facility policy titled Comprehensive Care Plans, implemented on 4/11/25, showed:<br><br>. 1. The care planning process will include an assessment of the resident's strengths and needs . All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality .<br><br>3. The comprehensive care plan will describe, at a minimum, the following:<br><br>a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. f. Resident specific interventions that reflect the resident's needs and preferences.<br><br>Review of a facility policy titled, Care Planning-Resident Participation, implemented on 5/13/25, (continued on next page) |

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|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | showed, Policy: This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care).<br><br>Policy Explanation and Compliance Guidelines:<br><br>.9. The facility will honor the resident's right to participate in establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan.<br><br>11. If the participation of the resident and/or resident representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record.<br><br>There was no documentation that resident representatives were invited to participate in a care plan, that they attended a care plan conference, signed the care plan showing attendance or acknowledgement of it, or that their participation was determined not practicable. |

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| | 275159 | A. Building<br>B. Wing | 02/10/2026 |

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| Beartooth Rehabilitation and Nursing LLC | 350 W Pike Ave<br>Columbus, MT 59019 |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>Based on interview and record review, the facility failed to ensure binding arbitration agreements were presented in a manner allowing informed and voluntary consent, and failed to ensure arbitration agreements were not effectively treated as routine admission paperwork, for 3 (#s 6, 12, and 25) of 30 sampled residents. The failure placed the residents at elevated risk for signing binding legal agreements without informed choice and limiting access to the court system. Findings include:1. During an interview on 2/8/26 at 10:14 a.m., staff member A stated there were currently no signed arbitration agreements in the facility.<br><br>During an interview on 2/8/26 at 3:40 p.m., staff member F stated she was somewhat familiar with the admission packet and had completed the admission process with families a few times since she started working at the facility. Staff member F stated she did not separately review each individual document with the family unless questions were asked. Staff member F stated she was not familiar with what an arbitration agreement was or why someone would sign one, and did not know an arbitration agreement was included in the admission packet, stating, Oh wow, I would have assumed it was just an authorization to treat!<br><br>During a telephone interview on 2/8/26 at 4:15 p.m., NF6 stated she was the power of attorney for resident #6. She signed all legal documents and consents on her behalf. NF6 stated she completed and signed the admission documentation when her mother was admitted in November of last year (2025). NF6 stated she did not know what an arbitration agreement was, and it was not explained to her. NF6 stated she signed all the documents as she assumed they were all standard admission forms, and staff did not explain the documents as she was signing them. NF6 stated she would not want to sign an arbitration agreement for resident #6.<br><br>During an interview on 2/9/26 at 3:45 p.m., staff member A stated, The families probably just signed all the forms and didn't realize what they all were.<br><br>During an interview on 2/9/26 at 4:02 p.m., staff member J stated she signed the arbitration agreements, but was not responsible for explaining the forms to the families, stating, Usually [Staff member A] or a nurse would do that. Staff member J was unaware of any signed arbitration agreements in the facility at the time of the interview and stated they probably just signed the form, thinking it was part of the admission paperwork.<br><br>Review of a six-page facility document titled Arbitration Agreement, dated 11/21/25, showed the document contained the typed name of resident #6 on page one, along with the typed date of the document, and on page six, the signature of NF6 and the signature of staff member J.<br><br>2. During an interview on 2/10/25 at 11:17 a.m., NF2 was asked if the facility reviewed the arbitration agreement and explained the form to her. NF2 said No, I don't know what that means. NF2 then asked what an arbitration agreement was.<br><br>Review of resident #25's medical record showed an arbitration agreement form dated 10/30/25. The form was signed by NF2, but the signatures of the POA and facility representative were not dated.<br><br>During an interview on 2/10/26 at 9:15 a.m., staff member J said she gave the admission packet to resident #25's family member to sign. Staff member J said when she gave resident #25's family<br>(continued on next page) |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | member the packet, she told her that she could ask her about any questions she might have. Staff member J said she did not educate her on the arbitration agreement.<br><br>3. During an interview on 2/9/26 at 12:40 p.m., resident #12 stated she entered the facility in late November [2025]. Resident #12 stated she signed the admission paperwork when she arrived. Resident #12 stated she did not remember signing a binding arbitration agreement, or staff explaining to her what the binding arbitration agreement meant, or its conditions. Resident #12 stated she has not had any issues or disputes that have needed to be settled with the facility. Resident #12 stated, I was pretty foggy when I got here, not doing so good, and there was a lot (of papers) to go through.<br><br>Review of resident #12's Arbitration Agreement, dated 11/20/25, and signed by resident #12 and staff member J, showed:<br><br>This Arbitration Agreement. is made on this 20 day of November 2025, by and between [Facility Name] . and [Resident #12] . acknowledges that he/she is signing this Agreement as a party, both in his/her individual and representative capacity.<br><br>I. DAMAGESThe parties agree that damages awarded, if any, in the Arbitration shall be determined in accordance with the provisions of the state or federal law applicable to a comparable civil action, including any statutory caps or limitations on such damages.<br><br>II. ARBITRATION HEARING. The cost of the Arbitration, including the costs and fees of the Arbitrator shall be borne equally by each party. All claims based in part on the same incident. or related course of the care or service provided by the Facility to the Resident, shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose prior to the date upon which notice of arbitration is given to the Facility or received by the Resident, and is not presented in the Arbitration proceeding.<br><br>V. MODIFICATION OF AGREEMENTThis Agreement cannot be modified except in writing signed by both Resident and the Facility and supersedes any and all other agreements, either oral or in writing, express or implied, between the Resident and the Facility relating to dispute resolution.<br><br>X. RIGHTS OF THE RESIDENT. by signing this Agreement, the Resident and the Facility are giving up and waiving the right to have disputes decided in a court of law .<br><br>The facility failed to provide accurate documentation on the required entrance conference papers to include residents with signed binding arbitration contracts. The document provided by the facility showed, No Current Resident in Binding Arbitration, and Staff Responsible for Binding Arbitration: [Staff member J]. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on interview and record review, the facility failed to notify a resident's representative of changes in resident care and treatment for 1 (#25) of 30 sampled residents. The failure resulted in the POA's missed opportunity to be informed of changes to the resident's care and treatment. Findings include:Review of resident #25's nurse's note dated 11/8/25 at 3:52 a.m., showed resident #25 had a fall and was found on the floor next to the bed. The note showed the day shift staff would be responsible for alerting resident #25's power of attorney.Review of the nurse's notes for the remainder of 11/8/25 failed to show resident #25's power of attorney was notified about the fall.Review of resident #25's nurse's note, dated 12/5/25, showed resident #25 was started on an antibiotic for a urinary tract infection. There was no documentation showing resident #25's power of attorney was contacted regarding the change in treatment necessary to treat an infection.During an interview on 2/10/26 at 11:17 a.m., NF2 said the facility had not called her about any falls, and she had not been notified about resident #25 having a urinary tract infection or that resident #25 started on an antibiotic. Review of a facility policy titled, Care Plan Revisions Upon Status Changes, dated 4/11/25, showed, 2. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician and the resident representative . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to address the limited range of motion of the right hand for 1 (#1) of 30 sampled residents. This deficient practice increased the risk for further decline in the resident's functional ability and range of motion. Findings include:During an observation and interview on 2/8/26 at 10:04 a.m., resident #1 was observed seated in a wheelchair with her right hand in a flexed position with her fingers curled into the palm. When resident #1 was asked if she was able to open her fist, she stated, No. Resident #1 used her left hand to grasp the fingers of the flexed right hand and attempted to pull them open; the fingers did not fully extend.During an observation and interview on 2/9/26 at 8:03 a.m., resident #1 was observed during breakfast. Staff member L spoon-fed the resident. Resident #1 did not use her hands to assist with the meal. When asked about finger foods, staff member L stated resident #1 had not been able to eat with her hands since returning from the hospital on [DATE].During an interview on 2/10/26 at 8:08 a.m., staff member D said resident #1 did not have limited range of motion in her right hand upon admission and had experienced a decline following a recent hospitalization.During an interview on 2/10/26 at 8:13 a.m., staff member B stated if limited range of motion was observed and it affected the resident's activities of daily living, it should be included in the care plan.Review of resident #1's comprehensive care plan, last reviewed on 12/24/25, did not identify range of motion limitations for her right hand and did not include interventions to address the range of motion, positioning, or therapy evaluation.There was no documented evidence that the facility revised the comprehensive care plan to reflect the resident's decline in hand function or to implement interventions to prevent further loss of range of motion. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>Based on observation, interview, and record review, the facility failed to provide an activity program to meet the individual needs and interests for 2 (#s 9 and 29) of 30 sampled residents. The failure resulted in resident dissatisfaction with the activities program and boredom. Findings include. During an observation on 2/7/26 from 2:00 p.m. until 4:00 p.m., three residents were observed in the activity room doing a self-initiated activity.During an interview on 2/7/26 at 2:18 p.m., resident #29 said she was tired of Bingo, so she just stayed in her room and read. Resident #29 said there was not much to do at the facility when discussing her activity participation.During an interview on 2/7/26 at 2:33 p.m., resident #9 said the only thing to do for activities was to go to Bingo. Resident #9 said the activity director was new, and she did not know what to do for activities. Resident #9 said things were going on sometimes, but it the activities were not what she was interested in. Resident #9 said there were no activities going on during the weekend, except an occasional church group on Sundays. Resident #9 said the nurse working tomorrow (2/8/26) had planned a Super Bowl party for staff and residents, and if it wasn't for the nurse there would be no activities. Resident #9 said she was bored and spent a lot of time in her room. Resident #9 was sitting in her room with her back to the wall, watching her door. Resident #9 was not engaged in an activity.During an interview on 2/10/26 at 8:42 a.m., staff member X said she had been at the facility since the middle of December in the activity department. Staff member X said she got all her activity calendars preapproved before she put them out. The approval came through the COTA, but some things were occasionally approved through the activity department at a sister facility.During an interview on 2/10/26 at 9:05 a.m., staff member G said she oversaw the activities department because she was allowed to provide oversight due to her certification. Staff member G said the activity director came to her and they reviewed the activities for the month. Staff member G said she did sign off on the monthly calendars. Staff member G said she had not seen the monthly calendar for February 2026 yet. Staff member G said she was not aware that the residents were unhappy with activities.During an interview on 2/10/26 at 9:19 a.m., staff member A said she was not surprised there were problems with some activities for some residents. Staff member A stated that the activity director just started in December. The activity director tried, but some of the residents just sat there. Staff member A stated that some residents liked karaoke, but others did not and would not attend. During an interview on 2/10/26 at 11:35 a.m., NF1 said resident #29 frequently complained about the facility activities. NF1 reported resident #29 complained because the only activity offered was Bingo. NF1 said resident #29 said she would like to go on a drive or an outing, and maybe even go fishing, like they did in the past at the facility.Review of the facility activity calendars for February 2026 showed every Saturday and every other Sunday were documented to be resident choice activities for the entire day. There were twelve activities offered on a rotating basis weekly. No activities were offered past 3:00 p.m. for residents who wished to participate in an activity later in the day. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services to prevent a decline in range of motion for 1 (#1) of 30 sampled residents, and the range of motion limitations affected the resident and her ability to complete or participate in ADL care and increased the resident's risk of a continued deterioration in the resident's range of motion. Findings include: During an observation and interview on 2/8/26 at 10:04 a.m., resident #1 was observed seated in a wheelchair with her right hand in a flexed position with her fingers curled into the palm. When resident #1 was asked if she was able to open her fist, she stated, No. Resident #1 used her left hand to grasp the fingers of the flexed right hand and attempted to pull them open. The fingers did not fully extend during the attempt.During an observation and interview on 2/9/26 at 8:03 a.m., resident #1 was observed during breakfast. Staff member L spoon-fed the resident. The resident did not use her hands to assist with the meal. When asked about finger foods, staff member L stated resident #1 had not been able to eat with her hands since returning from the hospital.During an interview on 2/10/26 at 7:50 a.m., resident #1 was again observed during breakfast and required full assistance. Staff member M recognized the limited range of motion of resident #1's right hand and stated a therapy referral would be initiated.During an interview on 2/10/26 at 8:08 a.m., staff member D said resident #1 did have right-hand limited range of motion upon admission and had experienced a decline following a recent hospitalization.Review of resident #1's electronic health record showed she was hospitalized on [DATE] and returned to the facility on [DATE]. Review of resident #1's Discharge MDS, with an Assessment Reference Date of 11/1/25, showed under Section GG - Functional Abilities that resident #1 was substantial to maximal assist for all activities of daily living which included: eating, oral hygiene, toilet hygiene, showering/bathing, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene.Review of resident #1's Quarterly MDS, with an Assessment Reference Date of 12/17/25, showed under Section GG - Functional Abilities, that resident #1 was dependent on staff for eating, oral hygiene, toilet hygiene, showering/bathing, upper body dressing, lower body dressing, putting on and taking off footwear, and personal hygiene.The comparison of the MDS assessments demonstrated a decline in functional status following resident #1's hospitalization.Review of resident #1's comprehensive care plan, last reviewed on 12/24/25, did not show the facility identified the resident's right-hand range of motion limitations, and the care plan did not include interventions to address range of motion limitations for the resident, positioning, or a therapy evaluation. |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>Based on observation, interview, and record review, the facility failed to assess and provide services for 1 (#41) of 30 residents who exhibited signs of depression and was having a difficult time adjusting to the facility. The failure resulted in the resident feeling lonely, isolated and depressed. Findings include: During an observation and interview on 2/7/26 3:24 pm., resident #41 repeatedly told the surveyor he was sad and lonely. Resident #41 said he was basically kidnapped and placed here (at facility), as he did not know he was being left at the facility. Resident #41 said he was lonely; he missed his daughter and missed his granddaughter's dog. Resident #41 said he had a friend at the facility, but they kicked her out. Resident #41 said he cries every day. Resident #41 said he doesn't sleep well because he is lonely and cries almost every night. Resident #41 said he does sleep in the day to get some rest. Resident #41 said he goes to the dining room, but there is a group of residents who stare at him and talk about him. Resident #41 said that when the other residents talk about him, it makes him feel bad. During the interview, resident #41 was observed with tears in his eyes when he was talking about being lonely.During an interview on 2/7/26 at 4:10 p.m., staff member J said resident #41 slept in the daytime because he was depressed. Staff member J said resident #41 had good days and bad days. Staff member J said she worried about resident #41 when his sister does not visit. Staff member J said, I would not be surprised that resident #41 feels depressed because the other residents stare at him and whisper to each other. Staff member J said some of the residents are awful to resident #41. Staff member J said resident #41 does not have an established group of friends. Staff member J said she visited with resident #41 as frequently as she could. Staff member J said she says good morning and goodbye every day, but the staff could do more for the resident. Staff member J said resident #41 was depressed and slept during the day. Staff member J said she would not be surprised if he cried some of the time. Staff member J said resident #41's insurance would be reviewed to determine if he would be a candidate for behavioral health. Staff member J said a new assessment for depression had not been completed recently. Review of resident #41's MDS, with assessment reference date of 11/17/25, showed the resident's depression score was a 10; moderate depression. Resident #41 was on an antidepressant; the effectiveness of the medication was charted as N/A (not applicable) 8 of 15 times when the medication effectiveness was to be monitored. Review of resident #41's care plan, dated 12/8/25, showed the resident would be referred to behavioral health as needed. The care plan failed to direct the staff on assisting resident #41 to deal with his depression or the negative interactions with other residents. Review of resident #41's progress notes, dated 2/9/26, showed resident #41 was referred to behavioral health. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on observation, interview, and record review, the facility failed to maintain complete and accurate clinical records by failing to include a documented admission agreement in the medical record for 1 (resident #17) of 30 sampled residents. The failure placed the resident at elevated risk for lack of clarity regarding services, responsibilities, and resident rights. Findings include:During an interview on 2/8/26 at 2:44 p.m., staff member A stated admission paperwork should be completed at the time of admission, and the paperwork would be the responsibility of herself, or staff member K. Staff member A stated at the time of resident #17's admission, she would have been responsible for his admission paperwork.During an interview on 2/8/26 at 9:40 a.m., staff member B stated that resident #17's admission paperwork could not be located.Review of resident #17's electronic medical record showed an admission date of 11/25/24. The medical record lacked admission documentation, including information for billing, and resident rights and responsibilities.Review of resident #17's social service note, dated 2/8/26, showed: Left voicemail to [POA name], residents POA and legal guardian explaining that there is no intake packet and that we needed to get the intake packet updated. Resident advocate asked for a phone call back to gather email address and/or fax number to get the intake packet to POA/legal guardian. [sic]Review of a blank facility document titled admission Agreement, showed the following, Now that you have decided to become a resident at [Facility Name], the next step is to complete an Admissions Agreement, which is a requirement of Montana law, and to complete all necessary financial plans. |