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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275030	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Transitional Care and Rehabilitation	1500 32nd St S Great Falls, MT 59405

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident with a history of elopements had a Wander guard in place and doors were secured for 1 (#1) of three sampled residents with elopements; and failed to ensure staff were aware of and employing appropriate fall interventions for 1 (#3) of 5 sampled residents with fall risks. Findings include:1. Review of a facility reported incident investigation indicated resident #1 eloped from the facility on 6/23/25 at approximately 8:00 p.m. and was found 7 blocks away and returned to the facility. A BIMS was completed and indicated resident #1 had a BIMS of 4/15, severely impaired. Review of resident #1's EHR reflected that resident #1 was admitted on [DATE] at 10:38 a. m. and had an elopement risk score of 1.0.Review of resident #1's nursing progress note, dated 6/23/25 at 3:15 p.m., reflected that a wander guard was placed on resident #1's left ankle. Review of resident #1's Baseline Care Plan, dated 6/23/25, reflected that resident #1 was not an elopement risk.Review of resident #1's referral notes, faxed 8/3/25, reflected that resident #1 had made little progression at [Facility Name] and had agitation, aggression, and continual exit-seeking behaviors. The referral also reflected the referring facility had a wander guard in place.During an interview on 8/5/25 at 10:50 a.m., staff member B stated resident #1 was not wearing a wander guard on admission because the facility's process required the resident to show a risk for elopement after admission, rather than based on a history of elopement. Staff member B stated that admission nurses were not given the opportunity to review the referral documents because the facility did not want the nurses to enter the admission assessments based on bias from the resident's history. During an observation and interview on 8/6/25 at 9:40 a.m., staff member M stated he was doing his weekly checks of the door alarms. The following observations were made during the walk-through:The 300-hall exit door alarmed when opened but was so quiet, the alarm could not be heard down the hallway.The 400B-hall exit door did not turn on. The alarm had been turned off.The 400A-hall exit door did not turn on. The alarm had been turned off.The 500-hall exit door by therapy did not have a lock. The door remained open to the public for therapy services.The back kitchen door was propped open with a rock, and a staff member was smoking outside the door.Staff member M stated that the nurses repeatedly unlock the alarms to go outside and smoke. Staff member M stated the facility had taken the keys away from the nurses because they left the alarms off, but then were receiving too many calls at night for alarms, so the keys were given back. Staff member M stated that a sign-out sheet was in the storage room for staff to get the key. Staff member M stated, They just need to take the keys away again. Staff member M then went to the nurse's station and notified the nurse that the doors were unlocked. Staff member H stated, Ok and returned to her computer work. Review of the Emergency Exit Key Sign-Out Log, not dated, reflected only one sign out on 7/18/25 to the 400B hall, and the signature was illegible. During an interview on 8/6/25 at 10:35 a.m., staff member A stated the keys had been taken away because nurses were unlocking the alarms and not relocking them. Staff member A stated she thought the problem had been addressed and only the nurse had access to the key. Staff member A stated she was not aware of the sign-out sheet. Review of the facility's policy, Elopements and Wandering Residents, no date, reflected: - This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.- a. Residents will be assessed for risk of elopement and unsafe wandering upon admission .2. During an interview on 8/5/25 at 12:10 p.m., staff member E stated the 300-hall only had four residents at high risk of falls. Staff member E stated he would know who a high fall risk was based on whether the resident had a mat next to their bed. Staff member E stated all residents at risk of falls receive a fall mat next to their bed. When asked about interventions for each resident, staff member E stated he follows the same interventions for all fall risks, including transfer based on care plan, shoes or socks for all, and toileting during rounds. Staff member E stated he was not aware of individual interventions for residents in their care plans.Review of the roster for 300-hall, not dated, reflected eight residents with a High fall risk.3. Review of the roster for 400-hall reflected 38 residents with, High fall risk.During an interview on 8/6/25 at 7:45 a.m., staff member G stated all residents were at risk of a fall. Staff member G stated he would look up each resident on the computer to determine what their care plan says, so he just keeps an eye on them all to help stop falls. Staff member G stated he only knew of one resident who was a high fall risk. Staff member G stated he was not aware the roster showed 38 high fall

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to ensure proper storage of respiratory equipment in resident rooms for 2 (#11 and 15); ensure the proper-storage and emptying of full urinals for 2 (#s 16 and 17); and ensure proper disposal of trash/recycling for 2 (#s 4 and 5) of 22 sampled residents. Findings include: 1. Recycling:a. During an observation on 8/6/25 at 11:10 a.m., resident #4 had nine soda pop cans on the floor, next to the bed, which were empty. Resident #4 was unable to answer questions as to why the empty cans were on the floor. b. During an observation and interview on 8/6/25 at 11:41 a.m., resident #5 had nine empty bottles of soda and 11 empty cans of soda pop on the floor, next to his bed, which were empty. Resident #5 stated he did not know where the recycling was located, so he left the items on the floor. A trash/recycling policy was requested on 8/6/25 at 12:55 p.m. Staff member A stated the facility did not have a policy specific to trash/recycling and cleaning of resident rooms. 2. During an observation and interview on 8/6/25 at 12:05 p.m., resident #11 had a suction machine on the floor between her bed and her nightstand. Resident #11 stated that the staff recently used the suction machine when she was having trouble breathing.Review of resident #11's nursing progress notes, dated 7/17/25, reflected respiratory therapy and the notes showed, .orally suctioned (with a yanker) for a large amount of thick white yellow secretions.3. During an observation and interview on 8/6/25 at 12:07 p.m., resident #15 had an incentive spirometer on a tabletop, sitting on his bed, with a partially filled urinal touching the mouthpiece of the incentive spirometer. Resident #15 stated he used the spirometer during the day. Resident #15 had a cup of water on the table. When asked how he had his urinal emptied, he stated he would have it emptied by the staff when he sees them. During an interview on 8/6/25 at 11:45 a.m., staff member K stated that respiratory therapy was responsible for checking respiratory machines, changing cannulas, and humidifiers. Staff member K stated the suction machine should never be stored on the floor.Review of the facility's policy, Cleaning and Disinfection of Resident-Care Equipment, no date, reflected: .f. For durable medical equipment, such as feeding pumps, staff shall store used/dirty equipment in the soiled utility room. The central supply clerk shall be responsible for terminal cleaning/disinfection in designated locations, covering the equipment to prevent dust and other contamination, and storing in the clean utility or other designated storage rooms.4. During an observation on 8/6/25 at 12:09 p.m., resident #16 had a full urinal sitting on the heater in his room. Resident #16 stated he did not want to be interviewed. 5. During an observation and interview on 8/6/25 at 12:12 p.m., resident #17 had a full urinal on the floor next to his bed, and there was urine spilled on the floor. Resident #17 stated he assumed someone would empty the full urinal, but did not know who or when it would be emptied. Review of the facility's policy, Disinfection of bedpans and urinals, no date, reflected:3. If the resident uses the bedpan and urinal at will, do not allow placement on the floor or on a bedside table that is used for eating or drinking.During an interview on 8/6/25 at 12:15 p.m., staff member C stated the resident should call and notify of the assistance needed, and the CNAs should be emptying the urinals immediately; they should be stored in a bag in the resident's nightstand, and urinals should not be on a table with an incentive spirometer and drinks. Staff member C stated that respiratory equipment should not be stored on the floor or near a urinal. Staff member C stated she was not aware of residents keeping empty soda pop cans in their rooms.