STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Heights Nursing and Rehabilitation	1807 24th St W Billings, MT 59102

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility neglected to ensure newly admitted residents were provided antibiotic and pain medications in a timely manner, to ensure the treatment of infections and pain was provided as necessary, for 3 (#s 73, 81 and 109) of 4 recently admitted residents. Resident #73 did not receive medications during his stay and resident #73 discharged home against medical advice. Resident #81 did not receive two doses of IV antibiotics which necessitated his re-admission to the hospital. Resident #109 was returned to the emergency room for further treatment. The neglect of care directly pertained to the facility pharmacy delivery program, oversight, and management of the system, and the medication system was not corrected in a timely manner to ensure negative resident outcomes, and neglect, were prevented. Findings include: 1. Review of resident #73's nursing progress notes showed he was admitted to the facility on [DATE] at 2:03 p.m., with a diagnoses of left lower lobe pneumonia and sepsis (infection). The note showed the medications were entered into the electronic medical record system and verified by two nurses. Review resident #37's pharmacist note, dated on 3/5/25 at 8:32 p.m., showed there was no irregularities noted. Review of resident #73's March 2025, medication administration records showed, No Order data found for MEDICATION ADMINISTRATION RECORD, No medications had been administered to resident #73 during his stay in the facility. Review of #73's social service note, dated 3/6/25 at 12:28 p.m., showed this was a late entry note, which included: [#73] and the family wanted him to leave the facility. The social services progress note showed resident #73 expressed that he wasn't being helped. This was the only note about what happened. There was no nurses not indicating there was any issue. I tried to call the resident and he didn't return my call. Resident #73 said the reason for him leaving was because medications were not being received. Resident #73 stated he suffers pain in his neck and back. Resident #73 has chronic pain and is under a pain contract. Review of resident #73's admission orders, as written and sent from the [Hospital Name] listed all his regular maintenance medications and showed the resident was to have received lovenox to prevent blood clots and the following medications for pain: - Tylenol 650 mg every 6 hours, (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Gabapentin 400 mg three times a day, - Ibuprofen 400 mg as needed three times a day, - Tizanidine 2 mg every eight hours as needed, - Oxycodone 5 mg every six hours as needed. Review of resident #73's facility order summary report showed the only two physician orders documented was for the head of resident #73's bed to be up to prevent shortness of breath, and for a pain to be assessed per a pain scale, three times a day. No documented results were observed for these orders. During an interview on 3/24/25 at 9:40 a.m., NF1 said from the time resident #73 arrived at the facility until the next morning, resident #73 did not receive any medications. NF1 stated, resident #73 was on routine pain medications, and the providers would try to get resident #73 the medications he needed so a proper discharge could be provided. NF1 said the resident left against medical advice due to the lack of care. During an interview on 3/27/25 at 1:47 p.m., staff member D said there were no entries made to resident #73's medication administration record. Staff member D said without anything on the EMAR (electronic medication administration record) medications wouldn't have been given. 2. Review of resident #81's nursing progress notes showed resident #81 was admitted on [DATE] at 3:50 p. m. In addition to resident #81's routine maintenance medication, resident #81 was to be given Cefazolin 2000 by intravenous route every eight hours. Review of the [Hospital Name] after visit summary showed resident #81 had been hospitalized and treated for right septic shoulder and methicillin resistant staphylococcus aureus bacteremia. The after-visit summary contained the medication orders resident #81 was to receive. This summary showed resident #81 would be managed with IV (intravenous) antibiotics with an anticipated end of therapy date of 3/1/25. Review of resident #81's medication administration record for February 2025 showed, no doses of the cefazolin antibiotic was administered. The time frame on resident #81's medication administration record showed the resident missed two doses of antibiotics before he was discharged back to the hospital on 2/7/25 at 12:21 p.m., which was just under 24-hours from admission. During an interview on 3/24/25 at 9:40 a.m., NF1 said resident #81 was sent back to the hospital because he needed his IV antibiotics. NF1 said resident #81 was being treated for a septic (infection) shoulder and he needed IV antibiotics to treat the condition. During an interview on 3/25/25 at 8:00 a.m., NF2 said that resident had not been seen at the facility until 2/7/25. NF2 said resident #81 had not received any of his IV antibiotics because the staff had not found them. NF2 said the IV antibiotics hadn't been mixed and both nurses were LPN's and not able to mix the medications. NF2 said it did not look like he was going to get a dose of antibiotics any time soon, so he was sent back to the hospital. NF2 said the facility tells the providers they have pharmacy issues figured out, but these things keep happening. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Review of resident 109's nursing note, dated 3/19/25, showed the resident was admitted at 6:00 p.m. with a diagnoses of cellulitis with an abscess of the left foot, abscess of left thigh, and narcotic dependence. Review of resident #109's progress note, written by staff member A, dated 3/20/25, showed resident #109 was distressed about her pain. The note showed, It was when there was a lull in the conversation that she began focusing on her pain again. Review of resident #109's medication administration order showed resident #109 was to be given Vancomycin HCL 1750 mg intravenously two times a day until 4/6/2025. Review of resident #109's medication administration record showed resident #109 was not given any doses of the IV Vancomycin which was ordered. According to the medication administration record, she should have received one vancomycin dose during the time between the admission and when she was discharged at 9:30 a.m., to the emergency room. Review of resident #109's notice of transfer/discharge form dated 3/20/25 showed, resident #109 was transferred to the emergency on 3/20/25 at 9:30 a.m. The form showed resident #109 was transferred to the hospital for her health and safety because resident #109 pulled her picc line out. Review of #109's nursing progress notes, dated 3/20/25, failed to show when resident #109 pulled out her picc line, was transferred to the emergency room, or her mode of transportation to the ER. Review of #109's nursing progress note, dated 3/20/25 at 6:18 p.m., showed resident #109 returned from [Hospital Name] emergency department. The note showed new physician orders were received for oral antibiotics for resident #109. Review of resident #109's medication administration record showed resident #109 was given Hydrocodone on 3/21/25 at 9:48 a.m., STAT for possible opioid withdrawal symptoms. Review of resident #109's nursing progress notes, dated 3/24/25 at 8:54 a.m., showed resident #109 was to receive Linezolid 600 mg for cellulitis (infection). The nursing note showed the facility was out of stock for the medication and no Linezolid was available in the Nexsys (automated dispensing unit) machine. Resident #109's infection was to be treated with Linezolid through 4/10/15 at 6:00 p.m. During an interview on 3/25/25 at 8:00 a.m., NF2 said medications were not entered timely on resident #109's medication administration record, and she missed doses of antibiotics. Resident #109 pulled her picc line out sometime after admission. NF2 said resident #109 was a chronic user of hydrocodone. While in the hospital resident #109 received dilaudid and oxycodone. NF2 said the pharmacy did not give the staff a Nexsys code, allowing the nurse to pull a medication out of the backup system, and resident #109 ended up back in the emergency room for pain management and to have her picc line replaced. NF2 said she saw resident #109 on 3/21/25, and resident #109 was going through opioid withdrawal as she was sweating, thrashing, restless, and anxious. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with staff member A and D on 3/25/25 at 11:00 a.m., staff member D said the facility started using a system for communication with the pharmacy to help improve communication and tracking. This is still early in its use but seems to be working so far. Staff member D said when the medications get ordered, and the pharmacy is aware of the physician orders by 2:00 p.m., the pharmacy ships the medications overnight, and the medications will be available the next day. If the medications aren't ordered prior to 2:00 p.m., the medications will not be delivered until two days later. Staff member A said there are medications that can be sent via a local satellite pharmacy. Staff member B said there are two local pharmacies which are used the most, but the facility will go anywhere needed to get the medications. During an interview on 3/25/25 at 11:09 a.m., staff member B said resident #109 was getting dilaudid and strong pain medications when she was in the hospital. She only had an order for hydrocodone when she admitted . She was having pain and pulled her picc (peripherally inserted central catheter) IV out. Staff member B said she tried to get resident #109 pain medications, but the correct prescription had not been sent to the pharmacy. Staff member B said she called the provider, and the prescription was sent to the pharmacy. The pharmacy sent a code which would allow the nurse to remove a dose of medication from the Nexsys system. The nurse did not enter the code in time, and the machine locked, preventing the removal of the narcotic. The nurse called the pharmacy for another code, but the pharmacy refused to give her another code. The resident did not get her pain medication. Staff member B said on the morning of 3/20/25, she contacted the provider, and a prescription was sent to a local pharmacy. Staff member B said she delivered Hydrocodone to the facility for resident #109, but she had been sent to the hospital. Staff member B also said resident #109 pulled her picc line out around 8:00 a.m. During an interview with resident #109 on 3/26/25 at 2:00 p.m., resident #109 said she did not get pain medication when she first came to the facility. Resident #109 stated, I thought I was going to die. Resident #109 stated her anxiety has gotten worse and now she is scared and afraid to be in pain. Resident #109 said she gets her pain medication on a schedule, except for one night nurse, and that nurse makes her wait for the pain medication. Review of #109's nursing progress note dated 3/24/25 at 8:54 a.m., showed resident 109 did not receive the am dose of linezolid 600 mg that was ordered twice a day for cellulitis. The nurses note showed there was no medication available in the nexsys (backup stock supply). Linezolid was ordered to start 3/20/25 to continue through 4/10/25. No doses were available to ensure antibiotics were given to resident #109, every twelve hours, as ordered by the physician. During an interview on 3/27/25 at 8:37 a.m., NF3 said he attended the QAPI meetings every month. NF3 said pharmacy issues were discussed, but the pharmacy issues revolved around the gradual dose reductions as recommended by the pharmacy. NF3 said the current pharmacy is located out of state, but the facility is trying to bridge issues with the help of local pharmacies. NF1 said he does not recall being informed of issues with getting particular medications. NF3 said he was not aware of any specific residents not getting antibiotics or pain medications. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/27/25 at 2:42 p.m., staff member E said the operating company just changed over pharmacies and medications are delivered to the facility from Idaho. The facility just initiated a system with the pharmacy to help with communication, and this will also allow for better tracking of medications. Staff member E said she was aware of some of the pharmacy issues, but not all of them, as she managed operations. Staff member E said she would expect the medical director would be made aware of issues with the pharmacy as the medical director is fairly involved in the facility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility nursing staff failed to ensure treatment was provided, according to acceptable standards of practice, for PICC lines, for 1 (#109) one sampled resident. Findings include: Review of resident #109's admission medication administration record, for March 2025, failed to show IV antibiotics were being administered by a picc line. The medication administration record showed the medication was supposed to be administered via IV. During an interview on 3/25/25 at 8:00 a.m., NF2 said medications were not entered timely on resident #109's medication administration record, and due to this, she missed doses of antibiotics. Resident #109 pulled her picc line out sometime after admission. NF1 said resident #109 ended up back in the emergency room for pain management and to have her picc line replaced. During an interview on 3/25/25 at 11:09 a.m., staff member B said resident #109 was getting dilaudid and strong pain medications when she was in the hospital. She only had an order for hydrocodone when she admitted to the facility. The resident was having pain and pulled her picc (peripherally inserted central catheter) IV out, and she was anxious. Staff member B said the removal of the picc line should have been documented in the EHR. Review of #109's nursing progress notes failed to show any information about the resident having a picc line, and failed to show the picc line was pulled out, by the resident. Review of Infusion Nurses Society (2011) Policies and procedures for infusion nursing. 4th edition. [NAME], Ma: Infusion Nurses Society, INC. showed: . 1. Once the catheter has been successfully removed, immediately apply light manual pressure to the site with a sterile gauze pad for one full minute. 2. Assess insertion site for redness, drainage, or hematoma then cover with a sterile gauze. Notify physician if any redness, drainage or hematoma noted. 3. Measure and inspect the catheter keeping catheter tip sterile. If any part has broken off during the removal, notify the physician immediately and monitor patient for signs of distress. Call 911 if distress noted. 4. Compare the measurement obtained with the pre-insertion measurements for the line and the arm circumference. Notify the physician of any differences. 5. Notify pharmacy that the PICC has been discontinued. Notify physician and supervisor of any PICC related complications. 6. Document all the above in the patient's medical record . [sic]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide physician-ordered medications at the prescribed dose and frequency, for 3 (#s 73, 81, and 109); and failed to ensure the availability of prescribed medications resulting in re-hospitalization for one 1 (#81) resident, resulted in 1 (#73) resident discharging against medical advice, and 1 (#109) resident experienced opioid withdrawal, of 4 sampled residents for medication concerns. Findings include: a. Review of resident #73's nursing progress notes, dated 3/5/25, showed resident #73 was admitted to the facility following a hospitalization. The nurse's notes showed the physician orders were being entered into the resident's electronic health record. Review of #73's pharmacist note, written at 8:32 p.m. on 3/5/25, showed there were no irregularities with the medications. The pharmacy note failed to show there were no medication orders in the resident electronic medical record. Review of #73's social services note, written on 3/6/25 showed no medications were given to resident #73 following his admission. The resident discharged against medical advice because the facility failed to administer medications. During an interview on 3/27/25 at 12:49 p.m., staff member B said there were no medications to give resident #73. Staff member B said there have been times when the medications for the facility have been stuck at other locations. b. Review of resident #81's nursing progress notes showed resident #81 was admitted on [DATE] at 3:50 p. m. In addition to resident #81's routine maintenance medication(s), resident #81 was to be given cefazolin (antibiotic) 2000 mg by intravenous route, every eight hours. Review of the [Hospital Name] after visit summary showed resident #81 had been hospitalized and treated for a right septic shoulder and methicillin resistant staphylococcus aureus bacteremia. The after-visit summary contained the medication orders resident #81 was to receive. This summary showed resident #81 would be managed with IV (intravenous) antibiotics with an anticipated end of therapy date of 3/1/25. Review of resident #81's medication administration record, for February 2025 showed, no doses of the cefazolin antibiotics were administered. The time frame on resident #81's medication administration record showed the resident missed two doses of antibiotics, before he was discharged back to the hospital, on 2/7/25 at 12:21 p.m. During an interview on 3/24/25 at 9:40 a.m., NF1 said resident #81 was sent back to the hospital because he needed his IV antibiotics. NF1 said resident #81 was being treated for a septic shoulder, and he needed IV antibiotics to treat the condition. NF1 said issues with pharmacy are an ongoing problem at the facility and it has not been taken care of. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/25/25 at 8:00 a.m., NF2 said that resident #81 had not been seen at the facility until 2/7/25. NF2 said resident #81 had not received any of his IV antibiotics because the staff was unable to locate them. NF2 said the IV antibiotics hadn't been mixed, and both nurses were LPN's, and were not able to mix the medications. NF2 said it did not look like he was going to get a dose of antibiotics any time soon, so the resident was sent back to the hospital. NF2 said the facility tells the providers they have pharmacy issues figured out, but these things keep happening. c. Review of resident #109's medication administration record showed resident #109 was not given any doses of the IV Vancomycin (antibiotic), ordered by the physician. According to the medication administration record, she should have received one vancomycin dose during the time between the resident's admission, and discharge, to the emergency room. Review of #109's nursing progress notes, dated 3/20/25, failed to show when resident #109 pulled out her picc line, that she was transferred to the emergency room, or what her mode of transportation was for going to the ER. Review of resident #109's medication administration record showed resident #109 was given Hydrocodone on 3/21/25 at 9:48 a.m., STAT for possible opioid withdrawal symptoms. During an interview on 3/27/25 at 11:49 a.m. staff member B said resident #109 could have been given hydrocodone at approximately 10:00 p.m. Staff member B said resident #109 did not have any hydrocodone to be administered. Staff member B said the discharging hospital did not send the actual prescription to the pharmacy for resident #109. Staff member B said she tried working with the pharmacy, from 10:00 p.m. until 8:30 a.m., the next morning, which was when resident #109 was finally able to get one dose of hydrocodone. Staff member B said by that time resident #109 was so anxious and in so much pain, she pulled her picc, for the IV antibiotics, out. Staff member B said she was able to finally get the narcotic for resident #109 from a satellite pharmacy. During an interview on 3/27/25 at 11:49 a.m. staff member B said she had not been trained on the Nexsys system. Staff member B said she had to figure it out by herself. Staff member B said the pharmacy does not send medication when a resident is admitted . Staff member B said the nurse enters the medication orders into the electronic health record, and if the orders are in before 2:00 p.m., the residents medications will be delivered the next morning. Staff member B said there have been malfunctions with the Nexsys system, and the system may have to be over-ridden if the medication is not a narcotic. Staff member B said when a narcotic is needed, the pharmacy will give the nurses a code to enter to allow the removal of the narcotic. Staff member B said there is a time limit on the code and if not used timely, the system will lock and the code will not work. Staff member B said there have been issues with the pharmacy. When the pharmacy is called, there is not always an answer, and the pharmacy may not return the nurse's call. Staff member B said if there is a storm and roads are bad, the medications may be held up and not arrive timely. Staff member B said the Nexsys does not contain all the inhalers ordered by the physicians. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/25 at 1:47 p.m., staff member D said the facility started using a system to improve the communication between nursing and the pharmacy. Staff member D said the pharmacy said the nursing staff need to use the Nexsys before calling a satellite pharmacy for medications. Staff member D said there are several pharmacies in [NAME] who contract with the facility. Staff member D said there were issues with the pharmacy, but processes were broken in the building as well. Staff member D said the IV antibiotic was found in a food refrigerator for resident #80. Staff member D said the only nurses in the building were LPNs and the medication was not identified as needing to be administered via IV push, diluted, or given IM. Staff member D said the pharmacy is being worked on as the location of the pharmacy recently changed to Idaho. During an interview on 3/27/25 at 3:04 p.m., NF4 said the pharmacy received the physician orders faxed to them. The orders are typed into the pharmacy software. The medications are filled and shipped at 4:00 p.m., for overnight delivery. If the medication orders are not received before 3:00 p.m., the medications will be sent for delivery the second day. NF4 said the weather conditions are outside of their control and medications may not be delivered timely. NF4 said the pharmacy let the facility know the box sent Monday, which should have arrived on Tuesday, did not arrive until Wednesday.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure necessary medications were available for use when residents were admitted , or prior to the first dose being administered, for newly admitted residents, which resulted in the residents not receiving the medications (pain and antibiotics) at all, or not timely, and this caused negative outcomes due to the significant medication errors, for 3 (#s 73, 81, and 109) of 4 sampled residents for medication errors. Resident #73 received no medications from admission to discharge; resident #81 did not receive IV antibiotics and needed to be sent back to the hospital for treatment; and #109 did not receive pain or antibiotic medications, as needed. Findings include: 1. Review of resident #73's nursing progress notes showed he was admitted to the facility on [DATE] at 2:03 p.m., with a diagnoses of left lower lobe pneumonia and sepsis. The note showed the medications were being entered into the electronic medical record system for #73. Review of resident #73's March 2025, medication administration records showed no medications had been placed on the medication administration record, and resident #73 did not receive any medication while he was a resident at the facility. Review of resident #73's admission physician orders, as written and sent from the [Hospital Name] listed all his regular maintenance medications and showed the resident should have received the following medications and the number of medication errors for each: - Tylenol 650 mg every 6 hours - missed three doses, - Duloxetine 20 mg - missed one dose, - Enoxaparin 40 mg - missed one dose, - Gabapentin 400 mg - missed two and possibly three doses, - Lidocaine 4% patch - did not have patch removed, - Pantoprazole 20 mg - missed two doses, - Tamsulosin 0.4 mg one dose missed, - Ibuprofen 400 mg - as needed three times a day for pain, - Tizanidine 2 mg every eight hours as needed for pain - potential for two doses missed, - Oxycodone 5 mg every six hours as needed for pain - potentially one or two doses missed. Review of facility order summary dated 3/5/25 showed resident #73 had an opioid dependence, osteoarthritis left hip, cervicalgia, low back pain, and muscle spasms. Resident #73 has chronic pain and is under a pain contract. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/24/25 at 9:40 a.m., NF1 said from the time resident #73 arrived at the facility, until the next morning, resident #73 did not receive any medications. NF1 stated resident #73 was on routine pain medications and would be having significant pain. NF1 requested the staff to encourage the resident to wait at the facility so prescriptions could be managed, and resident #73 could get medications and a proper discharge could be completed. NF1 said the resident left against medical advice. During an interview on 3/27/25 at 1:47 p.m., staff member D said there were no entries made to resident #73's medication administration record. Staff member D said without anything on the EMAR (electronic medication administration record) medications wouldn't have been given. Staff member said resident #73 discharged against medical advice because he had not been given medication. 2. Review of resident #81's nursing progress notes showed resident #81 was admitted on [DATE] at 3:50 p. m. In addition to resident #81's routine maintenance medication, resident #81 was to be given cefazolin, an antibiotic, 2000 mg (milligrams) by intravenous route, every eight hours. Review of the [Hospital Name] after visit summary showed resident #81 had been hospitalized and treated for a right septic shoulder and methicillin resistant staphylococcus aureus bacteremia. The after-visit summary contained the medication orders resident #81 was to receive at the facility, once transferred. This summary showed resident #81 would be managed with IV (intravenous) antibiotics and would need to stay on IV antibiotic therapy until 3/1/25. Review of resident #81's medication administration record for February 2025 showed, no doses of the cefazolin antibiotic was administered. The time frame on resident #81's medication administration record showed the resident missed two doses of antibiotics before he was discharged back to the hospital on 2/7/25 at 12:21 p.m. During an interview on 3/24/25 at 9:40 a.m., NF1 said resident #81 was sent back to the hospital because he needed his IV antibiotics. NF1 said resident #81 was being treated for a septic shoulder and he needed IV antibiotics to treat the condition. During an interview on 3/25/25 at 8:00 a.m., NF2 said that resident had not been seen at the facility until 2/7/25. NF2 said resident #81 had not received any of his IV antibiotics because the staff had not found them. NF2 said it did not look like the resident was not going to get a dose of antibiotics any time soon, so the resident was sent back to the hospital. 3. Review of resident 109's nurses note, dated 3/19/25, showed the resident was admitted at 6:00 p.m., with a diagnoses of cellulitis (infection) abscess of the left foot, abscess of left thigh, and narcotic dependence. Review of resident #109's medication administration record showed, resident #109 was not given any doses of the IV Vancomycin ordered. According to the medication administration record, she should have received one vancomycin dose during the time between the admission and discharge to the emergency room. Review of nursing progress note, dated 3/20/25 at 6:18 p.m., showed resident #109 returned from [Hospital Name] emergency department. The note showed resident #109 did not have a picc line replaced and new orders were received for oral antibiotics for resident #109. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Heights Nursing and Rehabilitation	1807 24th St W Billings, MT 59102

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of resident #109's medication administration record showed resident #109 was given Hydrocodone on 3/21/25 at 9:48 a.m., STAT for possible opioid withdrawal symptoms. Review of resident #109's nursing progress notes, dated 3/24/25 at 8:54 a.m., showed resident #109 was to receive Linezolid 600 mg for cellulitis. The nurses note showed the facility was out of stock and no Linezolid was available in the Nexsys machine. Resident #109's infection was to be treated with Linezolid through 4/10/15 at 6:00 p.m. During an interview on 3/25/25 at 8:00 a.m., NF2 said medications were not entered timely on resident #109's medication administration record and she missed doses of antibiotics. NF2 said the pharmacy did not give the staff a code allowing the nurse to pull a medication out of the backup system, and resident #109 ended up back in the emergency room for pain management, and to have her picc line replaced. NF2 said she saw resident #109 on 3/21/25 and resident #109 was going through opioid withdrawal as she was sweating, thrashing, restless and anxious. During an interview on 3/25/25 at 11:09 a.m., staff member B said resident #109 only had an order for hydrocodone when she admitted to the facility. She was having pain and pulled her picc (peripherally inserted central catheter) IV out. Staff member B said she tried to get resident #109 pain medications, but the correct prescription had not been sent to the pharmacy. Attempts to obtain the medication were unsuccessful, and the resident did not get her pain medication. During an interview with resident #109 on 3/26/25 at 2:00 p.m., resident #109 said she did not get pain medication when she first came to the facility. Resident #109 stated, I thought I was going to die. Resident #109 stated her anxiety has gotten worse and now she is scared now and afraid to be in pain. Review of nursing progress note dated 3/24/25 at 8:54 a.m., showed resident 109 did not receive the a.m. dose of linezolid 600 mg that was ordered, twice a day, for cellulitis. The nursing note showed there was no medication available in the Nexsys (backup stock supply). Linezolid was ordered to start 3/20/25 to continue through 4/10/25. No doses were available to ensure antibiotics were given to resident #109 every twelve hours as ordered by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	03/27/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to provide palatable food; cooks were not following the facility menu; and the dietary department failed to provide foods specified on the resident's meal tickets, for 5 (#s 1, 37, 46, 69 and 92) of 24 sampled residents. These deficient practices had the potential to affect the quality of life and nutritional status of the residents. Findings include: During a lunch observation and interview on 3/25/25 at 1:00 p.m. residents #37 received a serving of mashed potatoes with brown gravy, macaroni salad, and chicken salad. Resident #37's friend was assisting him with his meal. When asked if the food tasted good, he shook his head no, and grabbed his friend's hand. Resident #37 did not receive a vegetable on his plate. During a lunch observation and interview on 3/25/25 at 1:02 p.m., resident #69 was observed to have mashed potatoes with brown gravy, macaroni salad, and a meat salad. Resident #69 states she doesn't like tuna salad. Staff sitting nearby had to tell resident #69 what the meat salad was. Resident #69 did not receive a vegetable. Resident #69 said the food did not taste good. During a lunch observation on 3/25/25 at 1:06 p.m., resident #46 and #92 received mashed potatoes with brown gravy, meat salad, and macaroni salad. These residents did not receive a vegetable. During an observation on 3/26/25 at 12:50 p.m., resident #1 was served baked ziti and carrots. The pasta in the main entre appeared overcooked, the tomato meat sauce looked pale mushy and overcooked. Resident #1's meal ticked showed resident #1 did not like carrots and did not like pasta. Resident #1 said she wasn't going to eat the carrots but had eaten some of the pasta. Review of the diet extension menu for 3/25/25 showed the Grove Menu to be served was a chicken salad sandwich, macaroni salad, grapes, and a vegetable medley. The menu did not show mashed potatoes and gravy as a substitute for any of the therapeutic diets or alteration in texture. During an interview on 3/25/25 at 1:30 p.m. staff member J said a new cook was being trained. She said the cook came from a hospital setting and was just learning about the menus. Staff member J said the mashed potatoes should not have been substituted for the vegetables. Staff member J said she should have been monitoring the meal she served, and the potatoes should not have been served, but a different vegetable should have been given.