

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2025
NAME OF PROVIDER OR SUPPLIER  Skyline Heights Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0656  Level of Harm - Actual harm  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.  (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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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure a resident's comprehensive care plan contained information related to the diagnosis, care, and monitoring of a diabetic ulcer on a resident with a history of diabetes and neuropathy for 1 (#1) of 13 sampled residents. Findings include: Review of a facility document titled Nurse/Provider Communication Form, dated 1/23/24, showed the resident presented with an open friction area to the right great toe and a scabbed area to the right middle toe. Review of a document titled, Wound Tracker Form, dated 6/29/24, showed Resident #1 was seen by wound care that day, and notes showed the resident had wounds on the Right distal 4th and 5th toe, both due to being cut while clipping his nails. The resident had a documented history of toe wounds. Review of resident #1's diagnoses list showed: -Type II Diabetes Mellitus without complications, with a date of 5/28/25, and a created date of 5/29/25 (identified on readmission), -Polyneuropathy, unspecified, with a date of 5/28/25, and a created date of 5/29/25 (identified on readmission), -Type 2 Diabetes Mellitus with Foot Ulcer, with a date of 9/25/25, and a created date of 10/21/25 (identified during stay), -Non-Pressure Chronic Ulcer, of Other Part of Right Foot, With Fat Layer Exposed, with a date of 9/25/25, and a created date of 10/21/25 (identified during stay). Resident #1's diagnosis list showed the facility did not identify the diabetic ulcer on resident #1's toe until September 2025. The facility did not add it to the resident's diagnoses list until 10/21/25. Review of resident #1's care plan, with a revision date of 10/22/25, showed: -Focus: Risk for alteration in skin integrity r/t DM2, ESRD, CVA incontinence, weakness, date initiated: 6/4/25. -Goal: Skin will not show signs of skin breakdown through the next review date, date initiated: 6/4/25. -Interventions: Rx'd Tx to R great toe diabetic ulcer (see orders), date initiated: 10/21/25. -Assess need for ADL assistance in bed mobility and transfers, provide assistance as needed, date initiated: 6/4/25. -Notify physician as needed, date initiated: 6/4/25. -Weekly skin assessment per facility protocol, date initiated: 6/4/25. The comprehensive care plan did not show the residents history of sores on the feet, even though the resident had identified skin/foot problems back in 2024, and the plan did not contain information on the resident's current condition until 6/4/25. The comprehensive care plan also failed to provide preventative interventions for resident #1's diabetic foot ulcer or issues with the feet. During an interview on 10/29/25 at 10:32 a.m., staff member F stated if she noticed a change with a resident or if there was a new skin issue, she would notify the nurse, and the nurse would add the concern to the care plan. Staff member F also stated the nurses would let staff know of any changes added to the care plan, which would occur during shift change report. During an interview on 10/29/25 at 1:05 p.m., staff member C stated the charge nurses are responsible for care planning for any newly identified resident issues or changes in the resident's condition. Staff member C stated she would expect nurses to include preventative measures in the care plan when an issue was identified with a resident. Staff member C stated care plans are what directs resident care and should reflect the resident's needs. During an interview on 11/5/25 at 10:25 a.m., staff member E stated she would add any changes in the resident to the resident's care plan, including interventions such as pressure-relieving mattresses, offloading boots for feet, and any other special needs. Staff member E stated that any preventative measures for a resident should be care planned. During an interview on 11/5/25 at 1:42 p.m., staff member D stated she would let the nurse know if a new skin issue was identified, and the nurse would care plan for the skin concern. Staff member D stated staff will read the resident care plans and would notify the nurse if there was something missing on the care plan. Resident #1's care plan failed to show his history of issues with the feet and failed to provide preventative interventions to guide staff in his cares.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to document the wound identified by the physician, to properly assess during skin checks, treat, and monitor a facility acquired diabetic ulcer for a resident with a history of diabetes, neuropathy, and sores on the feet, for 1 (#1) of 13 sampled residents. The deficient practice contributed to the deterioration of the wound, which resulted in the resident's right great toe being amputated. Findings include: On 11/4/25 at 11:45 a.m., the Administrator, Chief Nursing Officer, and Corporate Resource Nurse, were notified that an Immediate Jeopardy existed in the area of F684, Quality of Care, related to the failure to identify, monitor, and treat a diabetic ulcer for a resident with a history of neuropathy, diabetes, and sores on the feet. The failure resulted in the resident's hospitalization and amputation of the right great toe. This affected one resident (resident #1) of those sampled. The Severity and Scope identified for the Immediate Jeopardy were determined to be at the level of J. The facility provided an acceptable plan to remove the immediacy, and the plan was accepted by the State Survey Agency. Upon removal of the immediacy, the severity and scope were lowered to a G. The facility carried out the plan to remove the immediacy, which was verified onsite by surveyors, on 11/5/25 at 10:43 a.m. Review of resident #1's physician note, dated 6/27/25, showed: . He (Resident #1) also complained about some foot wounds as noted below. We discussed having him seen by wound care and he was amendable. The bilateral feet as imaged below with distal right great toe wound and the appearance of blisters of the distal left toes. The physician's Assessment/Plan showed: ? Ulcerative callus of the dorsal right great toe # left distal toe wounds .-would benefit from seeing wound care with his vasculopathy status, high risk-wound care referral placed today . [sic]a. Risk and History of Wounds: Review of a facility document titled Nurse/Provider Communication Form, dated 1/23/24, showed the resident presented with an open friction area to the right great toe and a scabbed area to the right middle toe. Review of a document titled, Wound Tracker Form, dated 6/29/24, showed Resident #1 was seen by wound care that day, and notes showed the resident had wounds on the Right distal 4th and 5th toe, both due to being cut while clipping his nails. The resident had a documented history of toe wounds. Review of resident #1's skin and wound evaluation documentation, dated 6/29/24, showed, . A. Describe . 22a. Other, specify, toe nails clipped to close . 23. Acquired: In-house Acquired 24. How long has the wound been present? . 1. New . G. Orders 1. Goal of Care: Healable .I. Progress .Notifications: No response .b. Diagnoses:Review of resident #1's diagnoses listing showed the following: - Type II Diabetes Mellitus without Complications, with a date of 5/28/25, and a created date of 5/29/25, which was on re-admission. - Polyneuropathy, Unspecified, with a date of 5/28/25, and a created date of 5/29/25, which was on readmission. - Pressure Ulcer of Other Site, Unstageable, with a date of 9/25/25, and a created date of 10/21/25, which was added during the resident's stay. - Type II Diabetes Mellitus with Foot Ulcer, with a date of 9/25/25, and a created date of 10/21/25, which was added during the resident's stay. - Non-pressure Chronic Ulcer of other Part of Right Foot with Fat Layer Exposed, with a date of 9/25/25, and a created date of 10/21/25, which was added during the resident's stay. The facility failed to identify the diabetic foot ulcer on resident #1's right great toe, identified by the physician in June of 2025, until September 2025. The facility staff did not add the right great toe wound to the diagnoses listing until 10/21/25.c. Care Plan: Review of resident #1's care plan showed, .Focus: [Resident #1] has physical functioning deficit related to: CVA, Repeated Falls, Other Lack of CoordinationInterventions: .-Inspect skin with care. Report reddened areas, rashes, bruising, or open areas to charge nurse, date Initiated: 8/16/23Focus: Risk for alteration in skin integrity r/t DM2, ESRD, CVA, incontinence, weakness, date Initiated: 6/4/25Goal: Skin will not show signs of skin breakdown through the next review dateInterventions: - Rx'd TX to R great toe diabetic ulcer (see orders) date Initiated: 10/21/25, Revision on: 10/22/25Notify physician as needed, date initiated: 6/4/25. Weekly skin assessment per facility protocol, date initiated: 6/4/25. Based on the review of resident #1's care plan, the facility did not identify the diabetic foot ulcer, the associated diagnoses, or pertinent interventions for the right toe ulcer until 10/21/25, and information was added to the care plan on 10/22/25. Although the resident had a long history of toe wounds, the care plan was shown to be ineffective, as shown by the delay in care, treatment, and documentation to address the right great toe wound. During an interview on 10/29/25 at 1:02 p.m., staff member C said that when a skin issue was identified, the nurses would write a progress note, which would alert administrative staff by use of the 24-hour report and it was then reviewed by the IDT. Staff member C stated care plans were reviewed</p>		

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F 0726  Level of Harm - 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.  (continued on next page)

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure staff had the competencies and skills to identify, assess, document, and monitor a diabetic ulcer for 1 (#1) of 13 sampled residents. This increased the residents' risk of infection and resulted in hospitalization and amputation of the resident's great toe. Findings include: Review of a physicians visit note, dated 6/27/25, showed resident #1 had a diabetic ulcer on the right great toe. Review of resident #1's weekly head to toe skin checks performed by the facility staff showed the following:- 7/2/25, No skin issues- 7/9/25, No skin issues- 7/16/25, No skin issues- 7/23/25, No skin issues- 7/30/25, No skin issues- 8/6/25, Skin issues noted, Left lower leg - scab, Right toe(s) - R great toe skin alteration. The licensed nursing staff did not properly assess and document the resident's skin concerns when skin checks were completed and failed to identify the wound documented by the physician on 6/27/25. The medication administration record for July and August 2025 did not show evidence that staff administered the physicians' order for Mupirocin External Ointment 2%. During an interview on 10/29/25 at 1:05 p.m., staff member C stated, We (management) go through all physician orders during our morning meetings. The nurses are responsible for care planning and are supposed to write a progress note based on the skin assessment every time a skin assessment is performed. Staff member C stated, I go around every morning and do a huddle with the nurses, and then nurses do a daily huddle with CNAs. Staff member C stated wounds should be looked at weekly by a physician during physician rounds, and a note should be documented. Staff member C stated the nurses should do a weekly skin assessment in PCC and evaluate the wound by measuring the healing of the wound, and if it is not healing, they should inform the provider. During an interview on 11/5/25 at 10:25 a.m., staff member E stated, I do skin checks weekly. Sometimes skin issues might get missed on the skin checks, it just depends on how thorough the skin check is done. If I do identify a skin issue during the assessment, I would document it in the TAR or right on the UDA. PCC auto populates residents who are due for a skin check each day. It is always good when the skin check can be done during a bath day. I feel they are more thorough then. If they aren't scheduled for bath days, then we try to do them while staff are doing cares. [sic] During an interview on 11/5/25 at 12:28 p.m., staff member E stated, .If a resident had ongoing skin issues it should be on the TAR, in progress notes, and in the care plan. Staff member E stated, I have not had formal wound care training, but I have learned a lot by assisting the wound care clinic that comes to the facility. The only specialized training I have received was for wound vacs. Staff member E stated, I am very confident in my ability to fill out skin assessments, I would say I'm a 10/10. Staff member E stated, She would look at feet, toes, and heels for anyone with diabetes. Staff member E stated, A nick on the toe can go a long way on someone with diabetes. Record review of resident #1's skin check documentation and progress notes showed licensed nursing staff did not identify resident #1's diabetic foot ulcer during weekly skin checks for the month of July, and the licensed nursing staff failed to follow-up with the physician after the identification of a diabetic toe ulcer on 6/27/25. During an interview on 11/10/25 at 1:30 p.m., staff member I stated he was the physician who identified concerns with resident #1's right great toe in June 2025. Staff member I stated it was his expectation of facility staff to identify and provide ongoing monitoring for diabetic residents with a history of toe wounds, and to provide preventative measures such as floating the heels, weekly skin checks, and diabetic foot care. Staff member I stated he communicated this to the facility as the standard of care. Review of the residents' medical record showed resident #1 went to a wound care appointment on 10/23/25 and was sent by the wound care facility to the hospital for IV antibiotic treatment and amputation of the right great toe. This was a result of the facility failing to provide necessary services for the early identification of the wound and ongoing treatment, to maintain communication with the physician, and to provide preventative interventions. Refer to F684 - Quality of Care - for more detail related to the resident's foot wound and care concerns.</p>		