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 04/23/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure the resident's medication regimen was thoroughly assessed and free from unnecessary medications that may cause sedation, for 1 (#1) of 9 sampled residents. Resident #1 was on hospice and had multiple medications for pain or agitation/behavior contributing to sedation. This was not addressed by the facility. The resident was sent to the hospital for further evaluation. Findings include:During an interview on 4/22/26 at 12:00 p.m., NF1 stated that when she arrived at the facility on 1/17/26, the resident was unconscious with minimal response to painful stimuli. NF1 stated resident #1 appeared to be sedated. The family decided to send the resident to the hospital for further evaluation. NF1 stated the resident had not returned to the facility. NF1 stated the resident passed away at the hospital. NF1 stated the resident was not conscious from admission to the hospital to the resident's passing away. NF1 stated the emergency room provider said the resident had an overdose of medications. NF1 stated the resident's level of consciousness had deteriorated so much and quickly that the family was shocked to see his condition when they arrived at the facility. During an interview on 4/23/26 at 10:14 a.m., staff members A and B were interviewed together. Staff member B stated the resident was referred to hospice services on 1/9/26, and was admitted to hospice on 1/13/26 for metastatic cancer. Staff member B stated the resident had orders for pain medication from the hospice provider, but was also seen by the in-house provider to discuss medications. Staff members A and B stated the resident had been under one-to-one (staff oversight) at the hospital before being admitted to the facility. Staff member B stated the resident's cognition and actions were impulsive with intermittent aggressiveness towards staff. Staff member B stated the facility had to initiate one-to-one supervision. Staff member B stated the one-to-one was successful in keeping the resident busy so he would not perseverate about wanting to get up and ambulate. Staff member B stated that even with the one-to-one supervision, he had been able to act quickly. The interventions implemented soon became unsuccessful, and the provider was notified and questioned if pain was one of the contributors to the aggressive behavior. The facility staff had several conversations with the family, and they had chosen to implement hospice services. When the resident displayed aggressive behaviors, the family was notified. At the time of implementation of hospice services, the resident continued one-to-one supervision. Hospice staff discontinued some of the resident's medications and added morphine and lorazepam. Staff member B stated the family had not been prepared for a decline in condition related to intake of food and fluids and the progression of the resident's disease process. Staff members A and B stated the resident was receiving pain medications. Staff members A and B stated the family was concerned about the dosage of medications the resident was taking. When the family arrived at the facility on 1/17/26, they had requested that the resident be sent to the hospital. Staff member B stated the facility had a discussion with the family regarding hospice services. Staff member B stated the facility had contacted the hospice nurse to update her on the resident's status and the family's wishes to send the resident out to the hospital. Staff members A and B stated there were no concerns with the resident's medications. Review of resident #1's Medication Administration Record, dated for the period of 1/5/26 through 1/17/26, showed the resident was taking the following medications: -12 doses of Prednisone 10 mg (a steroid). This medication was ordered on 1/7/26 for (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

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	04/23/2026

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one time daily for upper respiratory infection.-26 doses of quetiapine 125 mg (an antipsychotic). This medication was ordered on 1/6/26 for delirium and psychosis every eight hours.-Seven doses of hydrocodone 5/325 mg (opioid pain reliever). This medication was ordered on 1/14/26 three times daily for pain.-Eight doses of lorazepam 1 mg (antianxiety). This medication was ordered on 1/14/26 every four hours as needed for agitation.-Three doses of Morphine 0.5 ml (narcotic pain reliever). This medication was ordered on 1/14/26 for every four hours as needed for pain.-A one-time dose of olanzapine 5 mg at bedtime, scheduled (an antipsychotic) on 1/16/26 for agitation and anxiety.-On the day before the resident's transfer to the hospital, the resident was administered 5 mg of olanzapine, 10 mg of prednisone, 5/325 mg of hydrocodone, two doses of Ativan, 1 mg each, and 0.5 ml of morphine. On the day the resident was transferred to the hospital, he was given 1 mg of Ativan, 0.5 ml of morphine, and 10 mg of prednisone. Review of resident #1's progress notes from the resident's admission to discharge, 1/5/26 through 1/17/26, showed combative and unsafe behavior. The resident had multiple medications for psychosis, pain, anxiety, and a steroid for an upper respiratory infection.The facility failed to review resident #1's medications as a contributing factor for sedation. The facility failed to assess resident #1's medications for duplicate therapy and adverse consequences. The resident only had a minimal response to painful stimuli when sent out to the hospital. Review of resident #1's Medication Administration Record, dated 1/1/26 through 1/17/26, showed the resident rated pain for three days, on a 1 to 10 scale, with 10 being the worst, as: 1/15/26 - 5/10, 1/16/26 - 3/10, and 1/17/26 - 7/10. Review of resident #1's ER visit documentation, dated 1/17/26, showed the resident was brought to the hospital for a decrease in level of consciousness. Review of resident #1's hospital emergency room progress note showed the resident was brought into the emergency room for an altered mental status. The resident was hypoxic prior to arrival and was receiving supplemental oxygen. Per report from the family, the resident had been more sedated at the facility lately. The resident did become more alert in the emergency room.Review of resident #1's hospital History and Physical, dated 1/17/26, showed the resident was reportedly ambulatory when he arrived at the facility. However, the resident became weaker with multiple falls at the facility. His speech became nonsensical and incoherent. The family was notified of his decline. The resident was placed on hospice care and prescribed hydrocodone and morphine to address pain. The family was concerned about how fast the resident had declined and wanted the resident to be seen at the hospital. Under the Assessment/Plan section of the History and Physical, it showed the resident's dementia and chronic encephalopathy may be exacerbated by disease progression and use of opioid use, possible steroid-induced psychosis, and electrolyte imbalance.