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	03/12/2026

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 0801 Level of Harm - Minimal harm or potential for actual harm 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. Based on interview and record review, the facility failed to ensure the dietary manager completed a certification program approved by a national certifying body or had higher education in a related field when the dietitian was not scheduled and working at the facility full-time (35 hours). The staff in the dietary department were not following sanitary practices or storing food properly, and this increased the ongoing risk of cross-contamination for anyone receiving food or products from the kitchen, and for deficient practices to continue. Findings include:During an interview on 3/9/26 at 11:52 a.m., staff member J stated she was not certified as a Dietary Manager. Staff member J said she was currently enrolled to complete a Certified Dietary Manager program, but she had a year to complete the course. Review of facility document titled, State Food Safety, received on 3/10/26, showed staff member J had a State Food Safety Food Manager Certification with an issuance date of 5/23/22.During an interview on 03/12/2026 at 11:35 a.m., staff member O said she provided oversight to the dietary department when she was in the facility once a week. The day she is in the facility, she monitored lunch service and did some education for the dietary staff. Refer to F812 - Food Storage/Safety/Sanitization, for concerns related to the dietary department and oversight.

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	03/12/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained throughout the kitchen; failed to ensure food located in the coolers was labeled and dated; and failed to ensure cooler temperatures were maintained in the food storage safe zone. This deficient practice increased the risk for the development of foodborne illnesses and unsanitary conditions for all residents who received food from the kitchen. Findings include:During the initial tour of the kitchen, on 3/9/26 at 11:52 a.m., the following observations and interviews were made:-The thermometer inside the reach-in refrigerator near the deep fryer showed a temperature of 50 degrees.-A plastic drinking cup of a creamy brown liquid and a plastic drinking cup containing pink liquid were stored in the walk-in cooler. Staff member J said it looked like the staff's drinks and should not be there.-A 5-gallon bucket of sauerkraut was not covered.-A plastic bag of breadsticks located in the freezer was not closed or dated when opened.-A plastic bag of green beans stored in the freezer was not closed or dated when opened.-The deep fryer oil had a film of brown residue floating on the surface. The fryer basket hanging over the deep fryer oil contained cooked chicken strips and French fries, showing the fryer was being used with the residue in the oil. -The burners on the right-hand side of the stove were soiled with dried white batter. The batter was on the burner grate and on the cooktop surface.Review of the temperature log on the reach-in cooler, near the deep fryer, with a date of 3/9/26 on the p.m. shift, showed:-3/2/26, p.m. shift; 42 degrees,-3/8/26, a.m. shift; 50 degrees,-3/9/26, p.m. shift; 45 degrees.The form did not show what had been done to correct the temperatures that exceeded the accepted parameters.During observations and interviews on 3/10/26 at 8:50 a.m., staff member M said the reach in cooler near the deep fryer temperature was too warm yesterday. Staff member M said the cord to the cooler was replaced, and now the temperature was staying within the proper temperatures. The thermometer in the cooler showed 40 degrees. Staff member M said staff were educated the day before about notifying the manager if the cooler temperature was too warm (out of an acceptable range).The following was observed:-Under the cooler by the fryer, the floor was soiled with debris causing it to look unclean, black, and greasy.-The deep fryer oil, on the left, was covered with brown floating debris. The oil was very dark brown, and the brown floating debris looked the same as on 3/9/26. -The right-hand stove grates were soiled with dried white batter. The batter was on the burner grate and on the cooktop surface. This was the same dried batter from 3/9/26.-The backsplash behind the burners had splatters of dried red food spots. Staff member J said kitchen staff did a weekly deep clean.-Inside the oven on the right, there was food debris and black food particles. -The handle of the Zephaire convection oven was sticky to touch.-Two gallons of milk in the reach-in cooler were opened but not dated for when they were opened. - One quart of Silk milk was open and not dated. - Numerous larger containers of juices, which were pink, yellow, light brown, dark brown, red, and orange in color, were not labeled or dated with the contents.During an interview on 3/10/26 at 8:52 a.m., staff member J said an in-service was conducted on 3/9/26 regarding the cooler temperature and what to do if the temperature was out of range. During an observation and interview on 3/10/26 at 8:59 a.m., staff member N was observed hand washing some dishes and loading dirty dishes into trays. Staff member N used a cloth that was sitting on the dirty dish of the dish area to pull the tray out of the dishwasher after the dishes were finished washing. Staff member N then pushed the new tray of dirty dishes into the dishwasher. The dishwasher was then cycled to wash the tray of dishes. Staff member N was observed scrubbing a large restaurant pan. After the tray of dishes was washed, staff member N pulled them out of the dishwasher with his soiled hands. Staff member N then put the restaurant baking pan into the dishwasher. After the pan had been washed, he used the same soiled towel that was sitting on the dirty dish table, grabbed the baking pan, and removed it from the dishwasher. At no time during this observation did staff member N wash his hands before touching the clean trays and clean dishes. (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	03/12/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff member N, when interviewed, stated he did not touch the clean dishes with his dirty hands. Staff member N said he did not touch the dishes, just the tray.Review of a facility policy titled Monitoring of Cooler/Freezer Temperature, dated 6/23/25, showed:1. Logs will be checked and logged twice per day by designated personnel 3. All refrigerator storage must be maintained at or below 41 degrees, unless otherwise specified by law 5. If the temperatures are found to be out of range, the supervisor will be notified immediately for corrective action.

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	03/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the the nurses failed to ensure enhanced barrier precautions were followed when performing wound care for 1 (#24) of 27 sampled residents and failed to ensure weekly documentation related to the monitoring and prevention of legionellosis was completed as part of the facility's water management plan. This deficient practice increased the risk for exposure to infectious diseases, including drug resistant organisms and legionellosis. Findings include:1. During an observation on 3/9/26 at 1:37 p.m., NF2 was observed providing wound treatments to resident #24's sacral pressure ulcer and bilateral heel pressure ulcers. NF2 was observed wearing a protective gown and gloves. NF2 used her gloved right hand to reposition the chair she was seated on, and without changing gloves, was observed debriding resident #24's right heel wound. The failure to change the soiled glove to a clean glove, increased the risk of cross contamination. During an observation on 3/9/26 at 1:46 p.m., staff member E was providing care to resident #24's right heel and sacral wound. Staff member E was standing at resident #24's bedside, and opening dressing packages, which were then placed on the bed. Staff member E was not wearing a protective isolation gown. Staff member E applied the wound dressing to resident #24's sacral wound and did not put on an isolation gown. During an interview on 3/11/26 at 7:22 a.m., staff member B said she would expect the wound nurse to wear a gown when changing dressings on a resident with a wound. Staff member B said that if a nurse was just standing and watching, then a gown wouldn't be necessary. Staff member B said if the nurse was providing the care and applying the dressing, she should have a gown on. During an interview on 3/12/26 at 7:30 a.m., staff member E said assisted NF2 with resident #24's wound care. Staff member E said after NF2 left the room, she applied the dressings to resident #24's heels and sacral area. Staff member E said she had a gown on during wound care. Review of the facility policy and procedure, titled Enhanced Barrier Precautions, with a revision date of 4/11/25, showed: . 2. Initiation of Enhanced Barrier Precautions: b. An order for enhanced barrier precautions will be obtained for residents with any of the following: -Wound (e.g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wound, and chronic venous stasis ulcers) and/or indwelling medical devices. 3. Implementation of Enhanced Barrier Precautions: -PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: -.wound care: any skin opening requiring a dressing. 2. During an interview on 3/12/26 at 8:45 a.m., staff member L stated he was new to his position and (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	03/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was unaware of the facility's water management program processes. Staff member L stated he was in the process of receiving training from staff member T remotely. During an interview on 3/12/26 at 8:50 a.m., staff member T stated he had been orienting staff member L on the facility's maintenance processes. Staff member T stated the facility was using the Direct Supply TELS system for monitoring and implementation of the facility's water management program. Staff member T stated he had discovered the previous Maintenance Director was not documenting water management, legionella prevention, monitoring, and testing. Staff member T stated the facility's Maintenance Director should perform weekly monitoring of the TELS system to ensure Legionella prevention. Review of a facility document titled F-880 Infection Control Legionella Plan and Monitoring, undated, showed the following: On December 1st, 2025, during internal document review, the previous Maintenance Director was not documenting Water Management and Legionella Prevention Monitoring and testing. This practice is not in compliance with 42 CFR 483.30, CMS Guidelines, or ASHRAE standards. This practice of not documenting had the possibility to affect the entire population of the facility. The current Maintenance Director was educated by a corporate life safety resource, and the computerized maintenance management system, Direct Supply TELS, is now in place to log and document these inspections in accordance with the requirements . [sic] Review of a facility document titled, Water Management Program, dated 10/17/23, showed the following data for the period of 3/1/25 through 3/1/26: Testing and monitoring of Water Management Plan for Legionella . Main Building . All these inspections, tests and measurements need to be documented and recorded . Review of the weekly testing and monitoring log showed the following dates were marked No action recorded: -4/12/25 through 6/7/25 -7/5/25 through 8/9/25 -9/27/25 -10/11/25 through 11/15/25 Review of the weekly monitoring log for the period of 3/1/25 through 3/1/26 showed 22 of 52 required weekly water management monitoring activities lacked documentation of completion for the facility's monitoring system. The facility's failure to consistently monitor and document the water management program increased the risk for Legionella growth and potential exposure to Legionella and legionellosis.

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	03/12/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure the resident received treatment and care in accordance with professional standards related to wound care, and failed to follow physicians' orders for the wound care for the resident's numerous wounds, for 1 (#2) of 27 sampled residents. This deficient practice placed the resident at risk for a deterioration in wounds or infections, and the concerns continued over several months. Findings include: During an observation and interview on 3/10/26 at 9:15 a.m., resident #2 was seated in his chair, using both limited verbal communication and his communication board to talk with the surveyor. Resident #2 told the surveyor that the staff did not always change the dressing on the wounds on his feet.During an interview on 3/10/26 at 10:09 a.m., NF6 said resident #2 told her the nurses don't consistently change the dressings on his feet and toes.During an interview on 3/11/26 at 10:55 a.m., NF3 said resident #2 had a complicated wound with an external fixation device. NF3 said the wound clinic sent the facility orders and directions for wound care, but the nursing staff did not follow them. NF3 said to circumvent the problem with the orders not being followed, resident #2 was brought to the wound clinic weekly. NF3 said it was tough to relay the importance of wound management (to the facility) due to turnover and the number of staff. NF3 said the wound nurse and the DON (Director of Nursing) were responsible for the wound treatment of the Tibial corticotomy. NF3 said the treatment consisted of cleansing the wounds, the application of dressings to the toes, and the management of the Tibial corticotomy. NF3 said, Overall, the communication between the facility and the clinic could be better, rather than the facility just not doing the treatment.Review of resident #2's December 2025 treatment logs showed:Treatment #1 - Starting 12/19/25, the staff will distract (pull out) the piece of bone the fixator is connected to 0.5 mm per day, and the order showed to pull out the large knob in the direction of the arrow and plus sign one quarter turn, two times per day, to equal 0.5 mm at 8:00 a.m. and 8:00 p.m. The treatment was to be done only by the wound nurse or the DON. The treatment record documentation showed the treatments were not completed as ordered.Treatment #2 - Right second toe diabetic ulcer: the order showed to cleanse the area and allow it to dry. Apply Betadine over the wound. Toes will be wrapped with a dressing for a surgical wound to foot. The treatment was not completed as ordered per the documentation.Treatment #3 - Hematoma to the top of the left fourth toe. The order showed to cleanse with wound cleanser and allow it to dry completely. Apply skin prep daily. The treatment was not completed as ordered per the documentation.Treatment #4 - Right foot, first toe amputation site. The order showed to ensure the area is cleansed and allowed to dry. Apply Betadine to the wound bed. Cover with ABD pad and wrap with kerlix to form a football dressing. Ensure there is enough padding for extra protection. The treatment was not completed as ordered per the documentation.Treatment #5 - Right foot hallux amputation site. The order was to cleanse and allow to dry. Apply Betadine-soaked gauze, cover with ABD pad, and wrap with kerlix. The treatment was not completed as ordered per the documentation.Treatment #6 - Wound care suspected deep tissue injury to the right foot, on the third, fourth, and fifth toes. The orders were to ensure the areas were cleansed and allowed to dry. Apply skin prep to the top of toes and between toes. The treatment was not documented as completed as ordered.Treatment #7 - Right leg pin care. The order was to cleanse the pins with wound wash and cover the pins with wound wash. Then cover pins with Xerofoam. Paint incision with Betadine once daily, then cover with Kerlix and Ace. The fixator required quarter-turn adjustments twice a day, every Tuesday, Thursday, and Saturday. The treatments were not completed as ordered per the documentation.Review of resident #2's January 2026 treatment logs showed:Treatment #1 - Starting 12/19/25, the staff were to distract (pull out) the piece of bone the fixator was connected to 0.5 mm per day. Then pull out the large knob in the direction of the arrow and plus sign one quarter turn, two times per day, to equal 0.5 mm at 8:00 a.m. and 8:00 p.m. The treatment was only to be done by the wound nurse or the DON. The treatments were not completed as ordered per the documentation.Treatment #2 - Right second toe. The order (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	03/12/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was to cleanse the area and allow it to dry. Apply Betadine over the wound. Toes were to be wrapped with wound dressing for the surgical wound to foot. The treatment was not completed as ordered per the documentation.Treatment #3 - Hematoma to the top of the left fourth toe. The orders were to cleanse with wound cleanser and allow it to dry completely. Apply skin prep daily. The treatments were not completed as ordered per the documentation.Treatment #4 - Right foot, first toe amputation site. The order was to ensure the area was cleansed and allowed to dry. Apply Betadine to the wound bed. Cover with ABD pad and wrap with kerlix to form a football dressing, and ensure there is enough padding for extra protection. The treatment was not completed as ordered per the documentation.Treatment #5 - Right foot hallux amputation site. The order was to cleanse the site and allow it to dry. Apply Betadine-soaked gauze and cover with ABD pad, then wrap with kerlix. The treatment was not completed as ordered per the documentation.Treatment #6 - Wound care suspected deep tissue injury to the right foot, on the third, fourth, and fifth toes. The orders were to ensure the areas were cleansed and allowed to dry. Apply skin prep to the top of toes and between toes. The treatment was not completed as ordered per the documentation.Treatment #7 - Right leg pin care. The order was to cleanse pins with wound wash and cover pins with wound wash, then cover pins with Xerofoam. Paint incision with Betadine once daily, cover with Kerlix and Ace. The fixator required a quarter-turn adjustment twice a day, every Tuesday, Thursday, and Saturday. The treatment was not completed as ordered per the documentation.Review of resident #2's February 2026 treatment logs showed:Treatment #5 - Right foot hallux amputation site. The order was to ensure the area was cleansed and allowed to dry. Apply Betadine-soaked gauze. Cover with ABD pad and wrap with kerlix to form a football dressing. Secure with coban and ensure there was enough padding for extra protection. The treatment was not completed as ordered per the documentation.Treatment #6 - Wound care suspected deep tissue injury to the right foot, third, fourth, and fifth toes. The orders were to ensure the area is cleansed and allowed to dry. Apply skin prep to the top of toes and between toes. The treatments were not completed as ordered per the documentation.Treatment #7 - Right amputation site. The orders were to cleanse the area with normal saline and peri-wound with soap and water. For the peri-wound skin, apply antifungal ointment. Wound filler silver alginate rope. The secondary dressing was an ABD pad, kerlix, and ace wrap. The treatment showed to offload using the football dressing and only wrap to the ankle. This was two times a week for one week. The treatment was not completed as ordered per the documentation.During an interview on 3/12/26 at 7:30 a.m., staff members B and E were present. Staff member E said she initiated the medical provider's (wound) orders, and the order would then be populated on the resident's treatment administration record. Staff member B said the treatment would be signed off on the treatment administration record sheet when completed. Staff member B said having the treatment administration record checked off showed the treatment was completed. Staff member E said it might have been her mishap when the treatment administration record was not signed off (for resident #2).

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	03/12/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medication carts remained locked when a staff member was not in attendance; and failed to ensure monitoring was completed as needed for the unit refrigerator temperatures that stored medications. This failure put the security of resident medications located in an unlocked and unattended medication cart at risk of theft or misuse, and placed residents who had refrigerated medications at risk for experiencing negative effects from improperly stored medications. Findings include: During an interview on 3/11/26 at 9:49 a.m., staff member Q stated it was her first time being assigned to work on the Rim View hallway. Staff member Q stated she was going slowly because she had not been shown the resident's preferences for medication pass previously.During an observation on 3/11/26 at 10:02 a.m., staff member Q was preparing medications to administer to a resident in his room. Staff member Q entered the resident's room and closed the door. Staff member Q left the medication cart unattended and unlocked in the hallway across from the resident's door. Staff member Q opened the resident's door after about two minutes to begin the medication administration with the surveyor present.During an interview on 3/11/26 at 11:13 a.m., staff member R stated a medication cart needed to be locked when a staff member left the medication cart unattended. Staff member R stated if a medication cart was in a hallway, staff should lock the cart before leaving it.Review of a facility policy titled, Medication Storage, dated 5/9/25, showed: . 1. General Guidelines:a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts.). c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.During an interview on 3/12/26 at 11:05 am, staff member A stated she could not provide records of the Rim View unit medication refrigerator logs. The logs would show the daily temperature checks and signatures showing staff checked the temperatures. Staff member A stated the refrigerator temperature logs were stored in a staff member's office and must have been moved when construction began in the facility, so she would check for the logs in storage.Review of a facility policy titled, ?Storage of Medication Requiring Refrigeration, dated 5/9/25, showed: . It is the policy of this facility to assure proper and safe storage of medications requiring refrigeration and to prevent the potential alteration of medication by exposure to improper temperature controls. 1. The facility must provide safe and effective storage of all drugs and biologicals in a locked storage area under proper temperature controls with limited access by authorized personnel consistent with state or federal requirements and professional standards of practice. 4. Refrigerators used for the storage of medications and biologicals:. d. Temperature should be maintained between 36-46 degrees F.e. Temperature should be monitored daily to ensure proper temperature control and documented on the temperature log with date, time, and signature of person performing the check clearly written. h. Historical temperature logs should be kept in a central location.A request to the facility was made on 3/12/26 for medication room refrigerator temperature logs for October 2025 through present. The facility did not provide logs of medication refrigerator temperatures for the Rim View unit by the end of the survey.

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	03/12/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure as needed psychotropic medications were limited to 14 days, unless the rationale for continuing the medication was documented by a medical provider, for 1 (#5) of 27 sampled residents. Findings include:During an interview on 3/12/26 at 12:02 p.m., staff member B stated that the as-needed psychotropic medication for resident #5 should have been discontinued after 14 days. Staff member B stated the medical provider would have to assess resident #5's need for continued use of a psychotropic medication, if they chose to continue the medication after the 14-day period, and then enter a new order. Staff member B could not explain why the as-needed psychotropic medication was not reviewed for continued use after day 14.Review of resident #5's physician order, dated 10/1/25, showed an order for trazodone HCL 100 mg oral tablet, give 50 mg by mouth, as needed for insomnia at bedtime. The as-needed order failed to include the 14-day duration for the psychotropic medication.Review of resident #5's medication regimen review, dated 11/1/25, showed the pharmacist notified the attending physician about the as-needed trazodone order. The form showed, . has an order for Trazodone 50 mg, taking 1 tablet at bedtime as needed along with a scheduled 50 mg tablet with no stop date indicated. The form showed the physician agreed with the recommendation and signed the form on 11/21/25.Review of the facility's policy titled, Use of Psychotropic Medication(s), dated 6/2025, showed, . a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or the prescriber for the rationale for the extended time period and indicate a specific duration.

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	03/12/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised to accurately reflect individual resident-centered care needs for 2 (#s 2 and 5), and identify a resident's preference for 1 (#5) of 27 sampled residents. Findings include:1. Review of resident #2's electronic health record showed resident #2's diagnoses included Diabetes Mellitus, End Stage Renal Disease on hemodialysis, Atrial Fibrillation, Congestive Heart Failure, Cerebral Vascular Accident, and amputation of hallux (bony bump at the base of the great toe) and second toe with dehiscence and necrosis of the bone. Review of resident #2's physician order, dated 2/13/26, directed the staff to monitor the dialysis port on the right side of resident #2's chest for signs and symptoms of infection and document. Review of resident #2's care plan, dated 8/16/23, showed the staff was to check access site daily fistula/graft/catheter - signs of infection. Monitor thrill and bruit daily and document findings; report abnormal findings to physician. The care plan was not updated to identify the change in dialysis access site from a fistula to an IV port. Resident #2's care plan did not include the name, location, or phone number of the dialysis clinic where he was treated. Resident #2's care plan did not include the dialysis treatment days, how he would be transported to dialysis, or the times when he would be picked up for and returned to the facility after dialysis. During an interview on 3/11/26 at 3:00 p.m., staff member B said the staff would not listen for a bruit and thrill as resident #2 had a central port. Staff member B said resident #2 had a fistula in the past, but it was not being used now. Staff member B said she helped update care plans while the facility's care plan process was being revised. During an interview on 3/12/26 at 11:35 a.m., staff member O said resident #2's only dietary restriction was a diabetic controlled carbohydrate diet. Staff member O said the facility updated the care plans. Review of resident #2's care plan showed he was on a no-added salt diet, with double protein portions and Nepro dietary supplement daily. A review of resident #2's physician's order dated 12/15/25 showed the resident was ordered to receive a controlled carbohydrate diet. The care plan was not updated to reflect the change in diet. 2. During an observation and interview on 3/9/26 at 3:55 p.m., resident #5 was in her room, seated in an electric wheelchair with a seatbelt secured around her waist. Resident #5 stated she used the seatbelt on her wheelchair to prevent her from slipping out of her chair. Resident #5 stated the wheelchair seatbelt made her feel safe. During an interview on 3/11/26 at 2:05 p.m., staff member AA stated it was up to the nurses to complete and update a resident's care plan. Staff member AA stated that if a resident utilized a seatbelt while in a wheelchair, the information would be in the resident's care plan. Review of resident #5's care plan, dated 1/23/26, failed to show interventions related to resident #5's use of a seatbelt while she is in her electric wheelchair. (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	03/12/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #5's power mobility indoor driving assessment, dated 8/14/25, showed resident #5's electric wheelchair seatbelt was used by the resident. Review of resident #5's occupational therapy note, dated 4/7/25, showed that resident #5 utilized the wheelchair seatbelt feature.

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	03/12/2026

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review, the facility failed to publicly post the total number and the actual hours worked for each required nursing staff category. This deficient practice limited resident and public access to required nurse staffing information. Findings include:During an interview on 3/10/26 at 3:10 p.m., staff member G stated the daily staff posting was not always completed with the actual staffing numbers and hours worked by required staff. Staff member G stated she had posted the number and hours for required staff based off the facility's staff schedule, but she did not always update the posting to reflect any changes. Staff member G stated she was not aware the actual number and hours worked by required staff needed to be posted.Review of the facility's daily staff posting information, dated 1/1/26 through 1/31/26, failed to show on 25 of 31 days the actual number and hours for required staff who worked each shift.