STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275021	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valle Vista Rehabilitation and Nursing LLC	402 Summit Ave Lewistown, MT 59457

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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
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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide a quadriplegic resident with a wheelchair after discharging and transferring him to an Adult Services Residential Program facility on the East coast and failed to document the transfer discharge of the resident in the medical record, for 1 (#2) of 4 sampled residents. This deficient practice resulted in a resident not having his main mode of locomotion. Findings include:During an interview on 11/5/25 at 8:00 a.m., NF3 stated when his ambulance service picked up resident #2, there was no wheelchair included in the resident's belongings that were to go with him on the transport to the Pennsylvania facility.During an interview on 11/5/25 at 8:32 a.m., staff member D stated having a wheelchair for mobility was important for resident #2 to get up to go to meals and sit at the nurses' station for extra supervision. During an interview on 11/5/25 at 8:59 a.m., NF5 stated he came to the facility a few days before resident #2 was to discharge to the Pennsylvania facility, to fit him for a new power wheelchair. NF5 stated when he found out resident #2 was transferring to a facility in Pennsylvania in a few days, he told facility staff there would not be enough time, and the Pennsylvania facility should start the process of ordering a new power wheelchair with another company in that area. NF5 further stated he was told there was not enough room in the ambulance for resident #2's current power wheelchair. Staff member B told him they were going to send a manual wheelchair with resident #2 on the transport to the Pennsylvania facility.During an interview on 11/5/25 at 9:16 a.m., staff member B stated the Pennsylvania facility did not want resident #2's power wheelchair, and she offered to send one of the facility's standard wheelchairs with the resident on discharge. Staff member B stated, To my knowledge, the standard wheelchair got on the ambulance with the resident (#2). Staff member B further stated, she had no documentation the standard wheelchair was sent on the ambulance with resident #2 to the Pennsylvania facility. Staff member B stated all the discharge documentation for resident #2 was through email and TEAMS (network communication and collaboration program) meeting discussions and not in the medical record as the facility normally would. During an interview on 11/5/25 at 10:25 a.m., NF7 stated she had a communication from the Pennsylvania facility, and resident #2 arrived at the Pennsylvania facility without a wheelchair (manual or electric).A review of resident #2's care plan, with a revision date of 10/14/25, showed, [Resident # 2] has limited physical mobility r/t spastic quadriplegic cerebral palsy requiring use of wheelchair for primary mobility.Review of resident #2's electronic medical record showed it did not have a discharge progress note the day of discharge, recapitulating his stay or what occurred during the discharge to include the resident did discharge from the facility, education of medications and treatments, belongings of the resident, who picked up the resident and when, and his reason for discharging. A review of a facility policy, titled, 'Transfer and Discharge (including AMA), with a revised date of 4/30/25, showed: Policy:It is the policy of this facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. This policy applies to all residents regardless of their payment source.8. For a transfer to another provider, for any reason, the following information must be provided to the receiving provider: .e. All special instructions and/or precautions for ongoing care, such as:i. Treatments and devices (oxygen, implants, IV's, tubes/catheters); .[sic]