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	06/04/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 3 (#s 4, 18, and 61) of 18 sampled residents. Findings include: 1. Review of resident #61's EHR, dated from admission on [DATE] to discharge on [DATE], showed the resident displayed frequent behaviors, which included refusing care, refusing to eat, refusing to use the call light, and yelling out for help for extended periods of time. The resident's refusals of care and yelling behavior continued throughout the resident's stay. The nursing notes showed the staff attempted to meet the resident's needs without a corresponding decrease in behaviors. During an interview on 6/1/26 at 12:30 p.m., NF4 stated resident #61 was admitted to the facility for strengthening physical therapy with a goal to return home with her spouse. NF4 stated he did not remember the facility discussing behavioral health services in an effort to manage resident #61's disruptive behaviors. When staff responded to resident #61, she did not always have an identifiable need and would become verbally abusive towards staff. During an interview on 6/4/26 at 11:11 a.m., staff member B stated NF4 refused to allow a mental health consultation to be done for resident #61, and the resident was not always compliant with taking lactulose (a medication used to decrease ammonia levels in the blood). The elevated ammonia levels were related to resident 61's diagnosis of chronic liver disease. Staff member B stated the resident's care plan addressed her behaviors for pain, nutrition, and functional status. Review of resident #61's Significant Change MDS, with an ARD of 9/8/25, showed areas triggered for care planning were behaviors and cognitive loss. Resident #61 was documented as having a BIMS of 11 out of 15, correlating to moderate cognitive impairment. The analysis of findings for the care area assessments of behaviors and cognitive loss showed, . She has behaviors of yelling for staff and not using the call light at times. She knows to use the call light and chooses to yell. She also refuses cares and often refuses to eat. [sic] The observable characteristics and extent of resident #61's cognitive loss showed, . confusion, disorientation, forgetfulness (observation, clinical record). Review of resident #61's care plan from 6/2/25 to 10/19/25 failed to show disruptive behaviors as focus areas. There were no interventions identified to address the resident's behaviors, and there were no revisions when interventions were not effective in reducing the frequency or severity of behaviors. The care plan failed to show the presence of disruptive behaviors or interventions implemented as a result of the resident's disruptive behaviors. 2. Review of resident #18's IDT (interdisciplinary team) progress notes, dated 5/12/26, showed that (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident #18 had a fall on 5/7/26. The interdisciplinary team identified the root cause of the fall for resident #18, the feet and floor were wet in front of the toilet. A recommended intervention to prevent further falls was to place grippy strips in front of the toilet. Review of resident #18's care plan, dated 5/11/26, showed the care plan was updated after the fall. The interventions showed, Since [Resident #18's] fall, he has been utilizing a wheelchair. He (resident #18) is able to operate with set up, please assist him if needed. The active care plan, dated 4/2/26, showed that resident #18 was often able to ambulate independently. The care plan did not include the grippy strips for the floor, which were placed in front of the toilet to prevent further falls. The care plan did not show that resident #18 used a walker for mobility/ambulation. During observations made on 6/1/26 at 3:45 p.m., 6/2/26 at 9:20 a.m., 6/2/26 at 9:20 a.m., and 6/3/26 at 12:26 p.m., resident #18 was observed using a walker when ambulating in the halls. During an interview on 6/4/26 at 8:45 a.m., staff member B said much of resident #18's variation in physical ability was due to fluctuations in his mental health. Staff member B stated resident #18 had told the staff he had been in the military and was shot (gunshot injury) in his hip. Resident #18 said that because of being shot, he had to use a walker. There was no evidence in the health record showing resident #18 was in the military. 3. During an interview on 6/4/26 at 11:18 a.m., staff member G stated that if a change occurred with a resident's plan of care, the CNA would be notified by the nurse on shift. Staff member G stated that resident #4 had tried glasses with colored vision lenses. Staff member G stated the glasses were in the social services office, and she was not sure if the resident was still using them. During an interview on 6/4/26 at 11:22 a.m., staff member J stated nurses could not change resident care plans, and the interdisciplinary committee was responsible for updating a resident care plan if a change occurred. Staff member J stated resident #4 was evaluated by outpatient services for vision issues and had trialed glasses with colored vision lenses. Review of resident #4's nurse progress note, dated 4/18/26 at 12:41 p.m., showed, . staff worked with [Resident #4] over lunch testing out filtered lenses . [Resident #4] used them for about ten minutes before she removed them and commented that she'd like to try them again in the morning. [Resident #4] said that the glasses worked, were durable, and they made a difference in one of her eyes. Review of resident #4's current care plan showed a referral was made for a vision evaluation. The care plan did not reflect the use of colored lenses as a new intervention for the resident. Review of a facility document titled, Care Plan Revisions Upon Status Change, revised 5/7/26, showed the following: . d. The care plan will be updated with the new or modified interventions.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on the interview and record review, the facility and staff failed to provide the necessary behavioral health services and oversight for a resident who displayed disruptive yelling, refusals of care, and verbal abuse toward staff regularly, and failed to document the resident's responsible party's refusal of behavioral health services. The medical record did not include evidence to show the facility consistently attempted to identify, trend, implement, monitor, or modify behavioral interventions consistently as the behaviors continued without change, to assist the resident with maintaining or improving her mental health and well-being, for 1 (#61) of 18 sampled residents. Due to these failures, the resident continued her disruptive yelling and refusals of care. Findings include:Review of resident #61's EHR, dated from 6/2/25 to 10/19/25, showed the resident displayed frequent behaviors, which included refusing care, refusing to eat, refusing to use call light, and yelling out for help for extended periods of time. Refusals of care and yelling behaviors continued to occur. The nursing notes showed the staff attempted to meet the resident's needs without a corresponding decrease in behaviors.Review of resident #61's physician progress notes, dated 6/4/25, 8/4/25, and 10/10/25, failed to address the disruptive behaviors documented by the nursing staff.During an interview on 6/1/26 at 12:30 p.m., NF4 stated resident #61 was admitted to the facility for strengthening physical therapy with a goal to return home with her spouse. NF4 stated he did not remember the facility discussing behavioral health services in an effort to manage resident #61's disruptive behaviors. When staff responded to resident #61, she did not always have an identifiable need and would become verbally abusive towards staff.During an interview on 6/4/26 at 11:11 a.m., staff member B stated one of the challenges in caring for resident #61 was NF4 wanted many of the medications discontinued. Staff member B stated NF4 refused to allow a mental health consultation to be done for resident #61 and the resident was not always compliant with taking lactulose (medication used to decrease ammonia levels in the blood). The elevated ammonia levels were related to resident 61's diagnosis of chronic liver disease.A request was made for any documentation related to the refusal of a behavioral health services consultation. No documentation was provided prior to the end of the survey.

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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 and interview, the facility failed to ensure staff follow safe food labeling and storage processes in accordance with standards for food service safety and failed to maintain sanitary conditions, including employee hygiene. These deficient practices affected all residents receiving food services from the facility's kitchen and dietary staff, and the deficient practices would continue if not addressed. Findings include: 1. During an observation and interview of the kitchen, on 6/1/26 at 11:42 a.m., the following conditions were present:- The maroon cereal bowls were stored upright in a bus tub. Staff member W said the bowls should be turned over when stored so stuff does not fall into the bowl.- Four large metal bowls were observed sitting upright on wire shelves. - A large unlabeled tub of dried beans was noted near the stove. Staff member W identified the contents of the container as pinto beans. Staff member W said the beans should have been thrown away.- Two opened plastic squeeze bottle of Smucker's strawberry jam were on the shelf near the stove. The label said keep refrigerated after opening. Staff member K said she had removed the jam from the cooler before breakfast in the morning.- Delicatessen ham and turkey were in separate plastic bags placed together in a large tub. The turkey was not dated, and the package was not open wide and not sealed. The ham package was not closed securely. - In a large tub on the bottom shelf of the cooler, what appeared to be thawed chicken was stored in plastic vacuum bags. There was no label to identify what was in the bag and the date the contents were removed from the freezer was missing. - On the third shelf from the bottom in the cooler, a large tub contained a tube of meat which looked like hamburger. The tube was not labeled with the contents or the thaw date. The meat was thawed out, and the tube was laying with one end of the tube hanging over the edge of the tub.- In a tub in the cooler, on the bottom shelf there were several packages of meat products. The meat was thawed but did not have a thaw date or a label identifying the meat product.- A large unlabeled and undated container full of a ground yellow meal was observed outside the cooler. Staff member W said the tub was full of cornmeal.- A large unlabeled and undated container full of white looking grain was observed outside the cooler. Staff member W said the contents of the container was rice.- The microwave interior was soiled with flecks of brown and white material. - The underside of the large stand mixer was soiled with brown and white dried debris.- Hot chocolate machine nozzles and the plate the nozzles were secured to was heavily soiled with dried hot chocolate. When staff member W was asked about the cleaning schedule, she said the nozzles were not cleaned often enough due to the amount of dried hot chocolate. - Juice nozzles on the juice dispenser were soiled and sticky from dried juice. When asked how often they were cleaned, staff member W said, Not often enough.- The following containers were open and not dated: soy sauce, vanilla, a gallon of vegetable oil, and a gallon container with butter/oil substitute. A bottle of vinegar was not dated, and the cap was off. - The walk-in freezer had several large mounds of ice on the shelves and on the floor.- Staff member T entered the kitchen without a hair net on. Staff member T walked through the kitchen to the juice machine. After the juice was obtained, she walked back through the kitchen and left through the door near the hand-washing sink. At no time did staff member T have a hair net on during the observation.- Staff member M did not have a beard cover on while working in the kitchen. Staff member M had a beard and mustache.During an interview during the kitchen walk-through, staff member W said she had just started working there a little over a month ago. Staff member W said she was not sure of all the facility policies. Staff member said she was one of three new employees in the kitchen, and there had not been time to do all the education yet. 2. During an observation on 6/1/26 at 12:50 p.m., in the large dining room, staff member M was wearing a beard net, which was not covering his mustache.3. During an observation on 6/1/26 at 12:57 p.m., the noon meal service started in the large dining room. Staff member K wore the same pair of gloves throughout the entire meal service. Staff member K touched the outsides of the bun bags and moved the tubs of soup bowls to the back table. Staff (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	member K took the temperature of the food and the soup. Staff member K paged through a three-ring binder to find the appropriate place to document the temperatures. Staff member K picked up a pen that was lying on the counter and wrote the temperatures in the binder. Staff member K then got the soup bowls out with gloved hands, putting her thumbs in the bowls when dishing up the soup. Staff member K was observed wearing the same gloves. Staff member K picked up the hamburger bun with her gloved hands and then placed condiments on the burger with the same gloved hands.4. During an observation on 6/2/26 at 8:40 a.m., staff member W was washing dishes. Staff member W was wearing gloves and placed dirty dishes into the dishwasher trays. Without removing her gloves and sanitizing her hands, staff member W picked up a clean cutting board and placed it in the cutting board rack. Staff member W began filling more dirty tray racks with water pitchers. After the dishwasher completed the cycle, staff member W, using the same dirty gloves, pulled the clean dishes out of the dishwasher. Staff member B noted the practice, identified that it was incorrect, and educated staff member W.5. During an observation on 6/2/26 at 8:47 a.m., staff member U had a mustache and was not wearing a beard net. Staff member U was also not wearing a hair net in the food service area. Staff member B said he should have a beard and a hair net on.6. On 6/03/26 at 8:37 a.m., staff member Y said the company would have a dietary manager from another facility come and spend some time training their dietary manager and the rest of the staff. 7. During an observation on 6/3/26 at 12:31 p.m., staff member M was serving food in the small dining room. Staff member M adjusted his beard cover while wearing gloves. Staff member M served food to the residents and pushed the food around with contaminated gloves. Staff member M, while wearing the same gloves, put his fingers inside the bowls when dishing up the soup.