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	07/02/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify the physician of a significant change in condition related to a chronic scalp lesion/wound, including new onset of drainage, for 1 (#3) of 7 sampled residents. This deficient practice resulted in the physician not being provided with timely information about a change in the resident's condition necessary to evaluate the need for additional assessment, treatment, or intervention. Findings include:During an observation on 6/30/26 at 2:50 p.m., resident #3 had a scalp lesion/wound with black discoloration, drainage, and a foul odor.Review of resident #3's weekly skin assessments dated 11/23/25, 11/30/25, and 12/7/25 showed there was documented drainage from the resident's scalp lesion/wound.Review of resident #3's nursing progress notes dated 11/23/25-12/9/25 showed no documentation that the physician was notified of the change in condition related to the development of drainage from the scalp lesion/wound.During an interview on 6/30/26 at 4:01 p.m., staff member C stated the physician should be notified of new skin concerns and changes in the size, shape, color, or drainage of a wound. Staff member C stated the physician was notified of changes on a case-by-case basis, and not every change in a wound was reported to the physician. Staff member C stated the physician was not notified of earlier changes to resident #3's lesion/wound because the physician was aware of the lesion when resident #3 was admitted to the facility.During an interview on 7/1/26 at 7:40 a.m., staff member D stated he did not recall being notified of concerns regarding resident #3's scalp lesion/wound before being notified of a maggot infestation.During an interview on 7/1/26 at 12:15 p.m., staff member G stated the physician should be notified of any change in a resident's condition or wound, including changes in size, color, shape, or drainage.Review of a facility policy titled Notification of Changes, dated 4/11/25, showed: Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician. when there is a change requiring notification. Compliance Guidelines:The facility must inform the resident, consult the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. 2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status.3. Circumstances that require a need to alter treatment.a. New treatment. [sic]Review of a facility policy titled Resident Change in Condition/Status, dated 3/3/26, showed: The nurse will notify the resident's attending physician or physician on call when there has been a change in the resident's condition or status.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure comprehensive wound assessment, monitoring, and documentation of a chronic scalp lesion/wound in accordance with accepted standards of nursing practice, including complete documentation of wound characteristics including size, shape, color, and drainage for 1 (#3) of 7 sampled residents. This deficient practice limited the ability to accurately monitor and evaluate changes in the resident's chronic scalp lesion/wound, identify changes in lesion/wound status, and determine when additional clinical evaluation or intervention was required. Findings include:Review of resident #3's weekly skin assessments dated 6/2/25-6/29/25, and 11/2/25-11/16/25, showed no documentation of the resident's chronic scalp lesion/wound.Review of resident #3's weekly skin assessment dated [DATE]-[DATE], and 12/14/25-6/14/26, showed the presence of a scalp lesion/wound. There was no documentation describing the scalp lesion/wound characteristics, including shape, size, and color.Review of resident #3's weekly skin assessment dated [DATE], 11/30/25, 12/7/25, 6/22/26, and 6/28/26, documented drainage from the scalp lesion/wound, but did not include a description of the lesion/wound characteristics, including size, shape, color, or characteristics of the drainage, including color, consistency, and odor.Review of resident #3's electronic medical record dated 6/12/26, showed no documentation of a comprehensive skin assessment of the scalp lesion/wound was completed following the identification and removal of maggots from the lesion/wound.During an interview on 6/30/26 at 4:01 p.m. staff member C stated skin assessments were completed weekly. Staff member C stated the physician should be notified of new skin concerns, and changes in the size, shape, color, or drainage of a wound. Staff member C stated the physician was notified of changes on a case-by-case basis and not every change in a wound was reported to the physician. Staff member C stated the physician was not notified of the earlier changes to resident #3's lesion/wound because the physician was aware of the area when resident #3 was admitted . Staff member C stated staff member D was notified of the infestation of maggots in the lesion/wound. Staff member C stated she did not complete a skin assessment after the maggots were removed.During an interview on 7/1/26 at 12:15 p.m., staff member G stated the physician should be notified of any change in a resident's skin condition or wound, including changes in size, color, shape, or drainage.During an interview on 7/1/26 at 1:22 p.m., staff member B stated the facility did not have a dedicated wound nurse and nursing staff completed wound care on the residents. Staff member B stated nursing staff were educated on skin and wounds by watching a wound series and completing Relias training. Staff member B stated the expectation was skin and wound assessments were completed and documented.During an interview on 7/1/26 at 2:54 p.m. staff member E stated the expectation for skin and wounds was to be assessed upon admission to determine whether skin concerns were present. Staff member E stated the nurse completes a full head-to-toe assessment and documents any findings. Staff member E stated if a resident had a wound the wound would be documented on the skin assessment and a separate wound assessment would be completed. Staff member E stated this allows the facility to follow the progression of the wound, good or bad. Staff member E stated the expectation was for nursing staff to document, at minimum, a description of the skin concern, wound measurements or size, shape, color, drainage, (including color, consistency, and amount) and odor.Review of a facility policy titled Resident Change in Condition/Status, dated 3/3/26, showed: To address changes in a resident's condition or status, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice.1. The nurse will notify the resident's attending physician or physician on call when there has been a change in a resident's condition or status.Review of a facility policy titled Wound Treatment Management, stated 5/6/26, showed: 1. Wound treatments will be provided in accordance with physician orders.2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. [sic]

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to provide the necessary care and services to evaluate, monitor, and manage a chronic scalp lesion/wound despite changes in the wound condition, including documented drainage; and failed to ensure timely wound management prior to and following the identification of a maggot infestation1 for 1 (#3) of 7 sampled residents. This deficient practice resulted in a decline of the resident's scalp lesion/wound condition and the development of maggot infestation1 requiring additional wound management and evaluation. Findings include:During an observation and interview on 6/30/26 at 2:50 p.m., resident #3 was observed with multiple, black-colored lesions on the scalp. A large central lesion approximately the size of a tennis ball was observed on the scalp. The lesion was black in color and partially covered with a brown-colored material. Yellowish, foul-smelling fluid was present. Resident #3's hair surrounding the lesions was discolored and had crusted, dried material present. Resident #3 stated she had one of the lesions for years, but the smaller ones were newer. Resident #3 stated the lesions drained off and on. Resident #3 stated she was seen by a surgeon recently, and he cleaned the wound and placed a Band-Aid on the larger lesion.During an interview on 6/30/26 at 3:05 p.m. NF1 and NF2 stated resident #3 was admitted to the facility with the skin lesion/wound. NF1 stated [Staff Member D] was aware of the lesion upon admission but only saw [Resident #3] on occasion. During an interview on 6/30/26 at 4:01 p.m. staff member C stated skin assessments were completed weekly. Staff member C stated she did not complete a skin assessment after the maggots were removed from resident #3's skin lesion/wound area. During an interview on 7/1/26 at 7:40 a.m., staff member D stated he did not evaluate or reassess resident #3 after notification that maggots were present in the scalp lesion/wound because the resident had an appointment scheduled with a general surgeon.During an observation on 7/1/26 at 10:07 a.m., resident #3's scalp continued to show yellowish, foul-smelling fluid. The resident's hair surrounding the lesions was discolored and had crusted, dried material present.Review of resident #3's weekly skin assessments dated 7/6/25-6/14/26, showed continued documentation of the presence of the scalp lesion/wound.Review of resident #3's weekly skin assessments dated 11/23/25, 11/30/25, and 12/7/25, included documentation of drainage from the scalp lesion/wound.Review of physician orders dated 11/1/25-6/12/26, showed no wound care orders for the scalp lesion/wound before 6/12/26.Review of resident #3's nurse progress notes dated 6/12/26 showed documentation that maggots were identified and removed from resident #3's scalp lesion/wound. There was no documentation of a comprehensive assessment of the lesion/wound following the removal of the maggots.Review of physician orders dated 6/12/26, showed wound care orders were initiated on 6/12/26 after maggots were identified and removed from the scalp lesion/wound. The orders were for staff to clean the wound daily with normal saline, pat dry, apply a generous amount of petroleum jelly, cover with an ABD pad, and secure with Kerlix.Review of resident #3's electronic medical record dated 6/12/26-6/17/26 showed resident #3 was evaluated by the general surgeon on 6/17/26, five days after the maggots were identified and removed from the scalp lesion/wound. During the five-day time frame following the identification of the maggots, there was no documentation of a physician or other provider evaluation or a comprehensive reassessment of the lesion/wound.Review of a document titled Consultation, dated 6/17/26, it showed resident #3 was evaluated by a general surgeon for the chronic scalp lesion/wound. The consultation noted, . fly laid maggots on it and has had drainage, odor, and growth occurring.has had occasion to be infected. biopsy taken.Review of the document titled Office/Clinic Notes, dated 6/25/26, showed the results of the biopsy were positive for basal cell carcinoma.Review of a facility policy titled Provision of Quality Care, dated 4/11/25, showed: . the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice.1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.Review of a (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	facility policy titled Resident Change in Condition/Status, dated 3/3/26, showed: To address changes in a resident's condition or status, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice.1. The nurse will notify the resident's attending physician or physician on call when there has been a change in a resident's condition or status.1Medical Maggot Therapy and Wound Infestation.Medical maggot therapy, also known as maggot debridement therapy, is a controlled medical treatment in which specifically bred, sterile larvae of the green bottle fly (Lucilia sericata) are used on select wounds under clinical supervision to assist with the removal of necrotic (dead) tissue. Medical-grade maggots are produced under controlled conditions to reduce the risk of introducing pathogens.Accidental maggot infestation (myiasis) occurs when flies deposit eggs in or near a wound or body tissue, resulting in an uncontrolled larval infestation. These larvae are not sterile, medical-grade larvae, and may be associated with infection risk, tissue damage, wound contamination, and the need for clinical assessment and intervention.References:Centers for Disease Control and Prevention (CDC). Myiasis. cdc.gov/myiasisU.S. Food and Drug Administration (FDA). Medical Devices; Surgical Devices; Classification of Maggots for Debridement Therapy.fda.gov

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on observation, interview, and record review, the facility failed to ensure physician supervision and ongoing clinical oversight following notification of a significant change in condition involving a maggot-infested scalp wound for 1 (#3) of 7 sampled residents. There was no documented physician assessment or reassessment of the resident's condition or additional clinical guidance to address the significant change in condition while the resident awaited outpatient surgical evaluation. Findings include:During an observation and interview on 6/30/26 at 2:50 p.m., resident #3 had multiple black-colored skin lesions on her scalp. Resident #3 had a large central lesion about the size of a tennis ball, black in color, and was partially covered with a brown-colored material. There was a yellowish, foul-smelling fluid present. During an interview on 6/30/26 at 3:05 p.m. NF1 and NF2 stated resident #3 was admitted to the facility with the skin lesion. NF1 stated [Staff Member D] was aware of the lesion upon admission but only sees [Resident #3] on occasion. NF1 stated the lesion drained intermittently.During an interview on 6/30/26 at 4:01 p.m., staff member C stated resident #3 was admitted with a large skin lesion on her head. Staff member C stated the lesion often had a foul odor. Staff member C stated on 6/12/26, a staff member told her resident #3 had maggots in her wound. Staff member C stated she assessed the resident and found the lesion to have a foul odor, and maggots were present. Staff member C stated she called staff member D. Staff member C stated staff member D told her to clean the area with soap and water, apply petroleum jelly, and cover the wound. Staff member C stated resident #3 received a shower and the lesion was dressed per the orders. Staff member C stated staff member D did not come to the facility to assess resident #3 following notification of the maggot infestation.During an interview on 7/1/26 at 7:40 a.m., staff member D stated he did not evaluate or reassess resident #3 after notification that maggots were present in the scalp wound because the resident had an appointment scheduled with a general surgeon.Review of physician progress notes dated 2/4/26 and 4/15/26 showed no documentation of a scalp lesion.Review of a physician progress note dated 6/10/26 showed, . Scalp lesion. The lesion on her scalp continues to enlarge in size. She denies any pain. There is [sic] been a strong odor. Assessment/Plan. 3. Lesion of the scalp.Concerning squamous cell carcinoma. Nursing staff discussed with family if they desire biopsy and potential treatment. This would need to be done by general surgery. They would like to have this evaluated. Will place referral to general surgery. [sic]Review of resident #3's electronic medical record dated 6/12/26-6/17/26, showed no documentation of a physician progress note following the notification of the maggot infestation on 6/12/26 until the resident's outpatient surgical evaluation on 6/17/26.Review of a facility policy titled Resident Change of Condition/Status, with an implementation date of 3/3/26, showed: To address changes in a resident's condition or status, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain complete and accurate medical records by failing to ensure the resident's medical record accurately reflected the presence, characteristics, and changes in a scalp lesion/wound for 1 (#3) of 7 sampled residents. This deficient practice resulted in an incomplete medical record that did not accurately reflect the resident's condition or provide a complete picture of the wound status, or care provided.Review of resident #3's weekly skin assessments dated 6/2/25- 6/29/25 and 11/2/25-11/16/25, showed no documentation of the resident's chronic scalp lesion/wound.Review of resident #3's weekly skin assessments dated 7/6/25-9/28/25 and 12/14/25-6/14/26, showed documentation of the presence of a scalp lesion/wound, but the record did not include complete documentation of the lesion/wound characteristics, including size, shape, color, and drainage characteristics.Review of resident #3's electronic medical record dated 6/12/26 showed no documentation that a comprehensive assessment of the chronic scalp lesion/wound was completed following the identification and removal of maggots from the lesion/wound.During an interview on 6/30/26 at 4:01 p.m. staff member C stated skin assessments were completed weekly. Staff member C stated she did not complete a skin assessment after the maggots were removed.During an interview on 7/1/26 at 1:22 p.m., staff member B stated nursing staff were expected to complete and document skin and wound assessments.During an interview on 7/1/26 at 2:54 p.m., staff member E stated the expectation was for nursing staff to document, at minimum, a description of the skin concern, wound description or measurements, shape, color, drainage, and odor. Staff member E acknowledged the medical record did not contain all the information necessary to provide a complete picture of resident #3's wound status and related care provided.

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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 facility failed to ensure Enhanced Barrier Precautions (EBP) were identified and initiated, including ensuring appropriate signage was posted and personal protective equipment (PPE) was readily accessible at the point of care for 4 (#s 1, 2, 3, and 7) of 7 sampled residents who either had wounds or an indwelling foley catheter; and the facility failed to ensure hand hygiene was completed in accordance with the Centers of Disease Control and Prevention (CDC) recommendations during the distribution of clean linen for 3 (#s 5, 6, and 7) of 7 sampled residents. These deficient practices had the potential to increase the transmission of infection throughout the facility. Findings include:1. Review of a facility document titled Residents on EBP, showed resident #1 had a wound, resident #2 had a wound and an indwelling foley catheter, resident 3 had a skin lesion, and resident #7 had a wound requiring enhanced barrier precautions.During an observation on 6/30/26 at 2:40 p.m., resident #3 had no enhanced barrier precautions signage outside the room or PPE readily accessible. There was one PPE caddy for the west hallway. Staff refers to this hallway as the SCU (Special Care Unit) hallway.During an observation on 6/30/26 at 2:43 p.m., resident #1 had no enhanced barrier precautions signage outside the room or PPE readily accessible.During an observation on 6/30/26 at 2:44 p.m., resident #2 was lying in bed and had an indwelling Foley catheter bag located in a basin on the floor. Resident #2 also had a documented wound. There was no enhanced barrier precautions signage outside the room or PPE readily accessible.During an observation on 6/30/26 at 2:50 p.m., resident #7 had no enhanced barrier precautions signage outside the room or PPE readily accessible.During an observation on 6/30/26 at 2:52 p.m., one PPE caddy was located in the hallway serving resident #s 1, 2, and 7. PPE was not located immediately outside or readily accessible.During an interview on 6/30/26 at 4:01 p.m., staff member C stated enhanced barrier precautions were to be used when a resident had an infection, wounds, or an indwelling Foley catheter. Staff member C stated she was verbally told which residents were on enhanced barrier precautions. Staff member C stated that residents on enhanced barrier precautions should have a sign showing a person with a shield posted on the door frame.During an interview on 7/1/26 at 12:15 p.m., staff member G stated she had not been working at the facility very long. Staff member G stated she was unsure which residents were on enhanced barrier precautions, and she did not know what the picture of the little man with a shield meant. Staff member G stated she had been educated on infection control during orientation.During an interview on 7/2/26 at 8:10 a.m., staff member M stated enhanced barrier precautions were to be initiated at the time of a qualifying event such as a wound or Foley catheter placement. Staff member M stated she notified staff of residents on enhanced barrier precautions verbally and tried to place a picture of a little man on the door frame. Staff member M stated she had missed placing enhanced barrier precautions signage for the four residents.2. During an observation on 7/1/26 at 12:25 p.m., staff member I was distributing clean clothing. Staff member I entered resident #5's room, opened the closet door, placed the clean clothing in the closet, and shut the closet door. Staff member I did not perform hand hygiene before entering or exiting resident #5's room. Staff member I walked back to the clean linen cart, and used her hand to move clean clothing down the rack to pick up resident #6's clothing. Staff member I picked up resident #6's clothing, entered the room, opened the closet, placed the clean clothing inside the closet, and closed the closet door. Staff member I exited resident #6's room and walked back to the laundry cart. No hand hygiene was performed before entering or exiting resident #6's room. Staff member I picked up resident #7's clean clothes from the linen cart, knocked on resident #7's door, opened the door, and entered the room. Staff member I walked over to the closet, opened the closet door and placed the clean clothing inside, shut the closet door and exited resident #7's room. No hand hygiene was performed prior to entering or exiting resident #7's room.During an interview on 7/1/26 at 12:33 p.m., staff member I stated she had been educated on proper hand hygiene and was to perform hand hygiene before entering a resident's room, after leaving (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a resident's room, and before touching any clean linen. Staff member I stated that she did not perform proper hand hygiene.Review of a facility document titled Enhanced Barrier Precautions, with a revision date of 5/14/26, showed: . Enhanced barrier precautions refer to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 2. Initiation of Enhanced barrier precautionsa. All staff receive training on enhanced barrier precautions upon hire and at least annually. b. An order for enhanced barrier precautions will be obtained for. wounds., indwelling medical devices such as . urinary catheters., even if the resident is not known to be infected or colonized with an MDRO.3. Implementation of Enhanced Barrier Precautions.a. Make gloves and gowns available immediately near or outside of the resident's room. d. Position a trash can inside the resident's room and near the exit for discarding PPE after removal prior to exiting. 10. Enhance barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device. [sic]Review of a facility policy titled Hand Hygiene, with a revision date of 5/6/25, showed: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.