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	05/20/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 41652 Based on interview and record review, the facility failed to ensure consent for the use of psychotropic medications was obtained prior to starting a psychotropic medication for 2 (#s 33 and 48) of 18 sampled and supplemental residents. Findings include: 1. Review of resident #48's physician order, dated 2/21/25, showed an order for citalopram hydrobromide, 10 mg, one tablet daily. The diagnosis associated with the order was, unspecified dementia, severe, with other behavioral disturbance. Review of resident #48's Informed Consent for Anti-depressant Medication Use, dated 2/24/25, showed, Note: All information must be explained, and consent obtained PRIOR to administering medication. The consent was signed by the resident's spouse on 2/24/25, after the medication was started. Review of resident #48's MAR, dated February of 2025, showed the first dose of citalopram hydrobromide, 10 mg, was given on 2/22/25, two days before the consent was completed. 2. Review of resident #48's physician order, dated 4/25/25, showed an order for sertraline HCl, 100 mg, one tablet daily. The diagnosis associated with the order was, Unspecified dementia, severe, with other behavioral disturbance and major depressive disorder, recurrent, moderate. Review of resident #48's Informed Consent for Anti-depressant Medication Use, dated 4/28/25, showed the consent was signed by the resident's spouse and dated three days after the medication order was received. Review of resident #48's MAR, dated April of 2025, showed the first dose of sertraline HCl, 100 mg, was given on 4/26/25, two days before the consent was completed. 3. Review of resident #33's physician order, dated 1/7/25, showed an order for citalopram hydrobromide 10 mg one tablet daily. The diagnosis associated with the order was depression related to vascular dementia, unspecified severity, with agitation and delusional disorders. Review of resident #33's MAR, dated January of 2025, showed the first dose of citalopram hydrobromide, 10 mg, was given on 1/8/25. Review of resident #33's EHR, accessed on 5/19/25, failed to show a completed consent for the use of citalopram hydrobromide. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of resident #33's physician order, dated 4/29/25, showed an order for haloperidol, 5 mg, every eight hours, as needed, for behavioral disturbance and agitation. Review of resident #33's Informed Consent for Anti-Psychotic (Neuroleptic) Medication Use, dated 5/1/25, showed the consent was signed by the resident's guardian two days after the medication order was received. During an interview on 5/20/25 at 10:18 a.m., staff member B stated staff member C was responsible for obtaining the consents for psychotropic medications. Staff member B was not able to explain why the consents were not completed prior to starting the psychotropic medications. Review of the facility's policy titled, Use of Psychotropic Medication(s), last revision dated 4/28/25, showed the resident or the resident's representative must be informed of the risks and benefits of the proposed treatment prior to initiating a psychotropic medication.

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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. 41652 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 2 (#s 33 and 48) of 18 sampled and supplemental residents. Findings include: 1. Review of resident #33's physician order, dated 1/7/25, showed an order for olanzapine, 5 mg, every six hours, as needed, for agitation or delusions related to vascular dementia and delusional disorders. The as needed order failed to include the 14 day duration for antipsychotic medications. Review of resident #33's medication regimen review, dated 1/9/25, showed no irregularities and failed to show the need to monitor the use of olanzapine after 1/21/25 (14 days). Review of resident #33's medication regimen review, dated 2/26/25, showed the pharmacist notified the attending physician about the as needed olanzapine order. The form showed, . CMS doesn't allow for PRN (as needed) antipsychotics for more than 14 days. Consider discontinuing this medication to comply with CMS guidelines. The form showed the provider agreed with the recommendation and signed the form on 3/5/25. Review of resident #33's MAR, dated January of 2025, showed the olanzapine order remained active until it was discontinued on 3/7/25. 2. Review of resident #48's physician order, dated 2/6/25, showed an order for quetiapine fumarate, 25 mg, every 24 hours, as needed, for agitation or anxiety related to severe dementia with other behavioral disturbance. The as needed order failed to include the required 14 day duration for the antipsychotic medication. Review of resident #48's medication regimen review, dated 2/26/25, showed the pharmacist notified the attending physician about the as needed quetiapine fumarate order. The form showed, . has an order for PRN (as needed) Seroquel (quetiapine fumarate) that started on 2/6 and only two doses have been needed. CMS prohibits the use of PRN antipsychotics for more than 14 days. Consider discontinuing this medication. The form showed the physician agreed with the recommendation and signed the form on 3/5/25. Review of resident #48's MAR, dated February of 2025, showed the quetiapine fumarate was active until it was discontinued on 3/7/25. During an interview on 5/20/25 at 10:18 a.m., staff member B stated staff member D was responsible for managing the monthly medication regimen review process. Staff member B stated staff member D was not available for an interview. Staff member B was not able to explain why the as needed antipsychotic medications were not reviewed for continued use after 14 days. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Use of Psychotropic Medication(s), last revision dated 4/28/25, showed, . b. PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 (#46) of 18 sampled and supplemental residents. This deficient practice increased the risk of allowing resident #46's further potential misappropriation of property when allegations were not reported and investigated with facility oversight. Findings include: Review of resident #46's electronic medical record showed an admitted [DATE]. Resident #46 had a diagnosis of [NAME] encephalopathy, with a family member as an appointed conservator. Review of resident #46's social services progress note, dated 3/6/25, showed involvement of an assigned APS investigator to investigate possible misappropriation of property, and IDT discussed the possible allegation. During an interview on 5/20/25 at 9:50 a.m., staff member C stated resident #46's conservator had been notified of a bill owed to [Facility - state hospital]. Staff member C stated she had been working with a former business office manager employee to stay in contact with resident #46's conservator for payment of the bills. Staff member C stated the former employee had terminated their employment with the facility recently and without much notice. Staff member C stated the concern with resident #46's conservator not paying bills owed to [Facility - state hospital] and the current facility was discussed in an IDT meeting. Staff member C stated she was not sure if a staff member had been assigned to follow-up with the concern after it was discussed in the IDT meeting. Staff member C stated resident #46's conservator stated he had to spend his own money to pay bills owed for resident #46. Staff member C stated she was concerned resident #46's conservator was spending the resident's funds for his own personal use. Staff member C stated resident #46's conservator was digging in his heels about what he felt was owed to the facility. Staff member C stated she notified the local APS supervisor on 3/5/25 with a referral concerning resident #46's funds being used by the conservator. Staff member C stated APS notified her on 3/6/25, of an assigned case worker to investigate the concern for resident #46's finances being used by his conservator. During an interview on 5/20/25 at 12:39 p.m., staff member A stated he was aware of staff member C's discussion of a concern with resident #46's conservator and handling of finances to pay bills owed by resident #46. Staff member A stated he was aware of involvement by an APS case worker. Staff member A stated, from his standpoint, the issue was more to do with payment of monies owed by the resident to several care facilities. Staff member A stated the issue with resident #46's conservator was needing to stay on top of him regarding payment of the bills owed by resident #46. During an interview on 5/20/25 at 1:11 p.m., staff member A stated staff member C might have had the impression resident #46's conservator was exploiting the resident. Staff member A stated the IDT believed the conservator for resident #46 was competent, and was just stubborn with money and did not want to pay resident #46's bills, unless he absolutely had to. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the State Survey Agency reporting portal failed to show a report of the allegation of exploitation involving resident #46. The facility was not able to provide any documentation of an investigation done by the facility with regard to the exploitation allegation. Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 4/16/25, showed: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . 2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law . 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written . III. Prevention of Abuse, Neglect and Exploitation . F. Providing residents, representatives, and staff information on how and to whom they may report concerns .and providing feedback regarding the concerns that have been expressed . V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . VII. Reporting/Response . 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: . b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .

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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. 48262 Based on interview and record review, the facility failed to notify the resident and or the resident's representative, in writing, of the reason for transfer when transferring a resident to the hospital, for 1 (#23) of 15 sampled residents. Findings include: During an interview on 5/19/25 at 2:37 p.m., staff member B stated the facility did not have a transfer notice for resident #23's hospitalization s on 3/7/25 and 5/9/25. Staff member B stated the nurse on duty was responsible for completing the transfer notice prior to a resident's transfer to a hospital. Review of resident #23's electronic medical record failed to include a transfer notice for resident #23's facility-initiated transfer on 3/7/25 and 5/9/25. On 5/20/25 a request was made for a copy of resident #23's Notice of Transfer, for the 3/7/25 and 5/9/25 facility-initiated transfers. No documentation or records were received from the facility by the end of the survey. Review of the facility policy titled, Transfer and Discharge (including AMA) Policy, dated 4/11/25, showed: - . Policy Explanation and Compliance Guidelines: - . 3. The facility's transfer/discharge notice will be provided to the resident or resident's representative in a language and manner in which they can understand.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48262 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan based on resident activity preferences and physical abilities, for 1 (#2) of 15 sampled residents. Findings include: During an observation on 5/17/25 at 12:15 p.m., resident #2 was lying in bed with the head of the bed elevated. The resident appeared to be sleeping. During an observation and interview on 5/18/25 at 8:00 a.m., resident #2 was lying in bed with the head of the bed elevated. The resident appeared awake and was wearing glasses, and the resident was staring forward at the television which was not turned on. Resident #2 stated she did not participate in activities because her vision was poor, and her hands did not work very well anymore. Resident #2 stated she had attended church service one time since she was admitted (4/17/25) to the facility. Resident #2 stated staff did not come into her room to do one-on-one visits and have never offered her activities or other things to do in her room. Resident #2 stated she would have liked staff to come into her room and visit with her since she was in her room most of the time. During an interview on 5/20/25 at 1:00 p.m., staff member E stated she was responsible for the residents' activity preferences and care planning. Staff member E stated the facility had changed computer applications, and the current program did not allow to customize resident interventions on the care plan. Staff member E stated activities documentation had been identified as an issue, and she needed to train her assistants on how to properly document activities in the resident's electronic medical record. Staff member E stated she was working in two different positions and had not been documenting as much as she had in the past due to limited time. Review of resident #2's Admission MDS section F, with an ARD of 4/23/25, showed under the Interview for Activities Preferences the questions and responses for the residents interests, and showed: -A. How important is it to you to have books, newspapers, and magazines to read? The response was marked as Somewhat important. -B. How important is it to you to listen to music you like? The response was Very important. -C. How important is it for you to be around animals such as pets? The response marked was Somewhat important. -D. How important is it for you to keep up with the news? The response marked was Somewhat important. -E. How important is it for you to do things with groups? The response marked was Somewhat important. -F. How important is it to you to do your favorite activities? The response marked was Very important. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-G. How important is it to you to go outside to get fresh air when the weather is good? The response marked was Very important. -H. How important is it for to you to participate in religious services or practices? The response marked was Very important. Review of resident #2's care plan, dated 5/17/25, showed: Focus: I exhibit independence in leisure activities manifested by my: My ability to choose group activities of interest. Interventions: - . Please encourage and support the continuation of my life roles. -Please encourage me to participate in activities of interest. - . Supply me with independent leisrure materials PRN. -Support my independent leisure choices. [sic] The care plan failed to identify and show resident #2's life roles, activities of interest, or provide one-on-one visit information. Review of resident #2's Admission MDS section GG, with an ARD of 4/23/25, showed the resident's functional abilities were primarily maximal assistance to dependent on staff for mobility and self-care. Eating was the exception and showed resident #2 required assistance with set-up and clean up from staff. The resident was not able to be independent with her leisure activities as shown in the resident's care plan.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 48262 Based on observation, interview, and record review, the facility failed to provide a resident with group and individual activities to meet the resident's interests, and support their physical, mental, and psychosocial well-being for 1 (#2) of 15 sampled residents. Findings include: During an observation and interview on 5/18/25 at 8:00 a.m., resident #2 was lying in bed with the head of the bed elevated. The resident appeared awake wearing glasses staring forward at the television which was not turned on. Resident #2 stated she did not participate in activities because her vision was poor, and her hands did not work very well anymore. Resident #2 stated she had attended church service one time since she was admitted (4/17/25) to the facility. Resident #2 stated staff did not come into her room, to offer and complete one-on-one visits, and they have never offered her things to do in her room to stay busy. Resident #2 stated she would have liked staff to come into her room and visit with her since she was in her room most of the time. Review of resident #2's activities participation record showed no participation in any activities since her admission on 4/17/25. During an interview on 5/20/25 at 1:00 p.m., staff member E stated she met with residents continually throughout a residents stay to identify activity interests. Staff member E stated she was responsible for completing a resident's activity preferences and care planning. Staff member E stated activities documentation had been identified as an issue, and she needed to train her assistants on how to properly document activities in the resident's electronic medical record. Staff member E stated she was working in two different positions, and had not been documenting as much as she had in the past, due to limited time. Staff member E stated resident #2 had participated in crafts, the Mother's Day party, resident council, church, and nail manicures since her admission. Staff member E stated documentation of resident #2's participation had not been completed in the resident's electronic medical record. On 5/19/25 a request was made for a copy of resident #2's activities assessment and documentation related to resident #2's activity participation, including one-on-one visits. No documentation or records were received from the facility by the end of the survey.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48262 Based on interview and record review, the facility failed to maintain complete medical records, including medical provider visit notes, for 4 (#s 2, 17, 23, and 32); and failed to ensure a resident's Provider Orders for Life-Sustaining Treatment (POLST) was signed by a medical provider for 1 (#33) of 15 sampled residents. Findings include: 1. Review of resident #2's electronic medical record, accessed 5/17/25 through 5/20/25, showed a lack of medical provider visit notes. Resident #2 was admitted to the facility in April of 2025. 2. Review of resident #17's electronic medical record, accessed 5/17/25 through 5/20/25, showed a lack of medical provider visit notes. Resident #17 was admitted to the facility in January of 2025. 3. Review of resident #23's electronic medical record, accessed 5/17/25 through 5/20/25, showed no medical provider visit notes. Resident #23 was admitted to the facility in February of 2025. 4. Review of resident #32's electronic medical record, accessed 5/17/25 through 5/20/25, showed no medical provider visit notes in resident #32's chart after December of 2024. Resident #32 was admitted to the facility in January of 2023. During an interview on 5/20/25 at 12:06 p.m., staff member B stated medical provider visit notes were received via facsimile from the medical provider to the facility. Staff member B stated the charge nurse reviewed the medical provider visit notes and placed the notes in a black file at the nurses desk which would then be scanned into the resident's electronic medical record. Staff member B stated after scanning had occurred the faxed copy was placed in the resident's paper chart file in a drawer at the nurse's desk. Staff member B stated the most recent medical provider visit notes had not been scanned into the resident's electronic medical record but could be found in the resident's paper chart in the drawer at the nurse's desk. Staff member B stated they were currently working on a process for the medical provider to directly enter the resident's medical provider visit note into the residents' electronic medical record in order for the information to be immediately accessible. Staff member B stated a facility nurse was always present with the medical provider during resident visits but did not document any information from the visit in the resident's electronic medical record. A review of resident #s 2, 17, 23, and 32's paper charts, located in a drawer at the nurse's desk, was completed on 5/20/25. No facility medical provider visit notes were located in resident #s 2, 17, and 23's paper charts. Resident #32's paper chart showed facility medical provider notes up to December of 2024. No facility medical provider visit notes were found after December of 2024 for resident #32. A request for documentation of medical provider visit notes was made on 5/19/25 for resident #s 2, 17, and 23, for the period from admission to May 2025. The medical provider visit notes for resident #32 were from January 2025 through May 2025. The medical provider visit notes were received from the medical provider's office via facsimile for the following dates: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #2: 4/29/25. -Resident #17: 1/8/25, 2/6/25, 4/29/25, and 5/15/25. -Resident #23: 2/13/25, 3/13/25, 3/18/25, 3/27/25, 4/17/25, and 4/24/25. -Resident #32: 2/20/25 and 4/29/25. Four residents currently residing at the facility did not have medical provider visit notes available in the resident's electronic medical record or in the paper chart located in a drawer at the nurse's desk. 5. Review of resident #33's POLST, dated 3/1/23, failed to show a physician's signature on the bottom of the form. During an interview on 5/19/25 at 3:10 p.m., staff member C stated she was responsible for ensuring the resident's POLST was completed correctly. Staff member C stated the POLST document in resident #33's medical record was completed when the resident was at a different facility. When shown a copy of resident #33's POLST, without a physician signature, staff member C stated, I can't believe I missed it. Better get that taken care of. Review of the facility's policy titled, Residents' Rights Regarding Treatment and Advance Directives, dated 4/11/25, showed: . 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart . The policy also showed: . 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process . The facility failed to identify the missing signature on resident #33's POLST.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on observation, interview, and record review, the facility failed to ensure an adequate infection prevention and control program was maintained, to include appropriate cleaning of facility equipment, and an annual review of all policies and procedures including the facility's water management system and Legionella surveillance. This deficient practice increased the likelihood of residents acquiring a healthcare-associated communicable disease or infection in the facility. Findings include: During an observation and interview on 5/19/25 at 4:26 p.m. with staff member E, the North hallway common bathtub was observed during a tour of a shower room. The bathtub had multiple long streaks of dark, rust color stains on the sides and floor of the tub. The drain had dried dark brown sediment around it. The bathtub did not have signage or a cover which notified staff and residents it was not to be used. Staff member E stated she had not cleaned the North hallway bathtub in maybe five or six months. Staff member E stated the bathtub was not being used by residents. She stated the only equipment used in the North hallway bathroom was the toilet and the sink. Staff member E stated she thought housekeeping audits were being done once a month by staff member A. Review of a facility policy titled, Cleaning and Disinfection of Resident-Care Equipment, dated 4/11/25, showed: . Resident Care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection . Follow manufacturer recommendations for cleaning equipment. Review of a facility policy titled, Water Management Program Policy, showed an effective date of April 2020, with no subsequent annual revision or review dates. Review of a facility policy titled, Legionella Surveillance Policy, showed an effective date of April 2020, with no subsequent annual revision or review dates. Review of a facility document titled, Facility Assessment, dated 8/7/24, showed: .Physical equipment .Resources .bathing tub .If applicable, process to ensure adequate supply, appropriate maintenance .Routine maintenance and cleaning schedules exist for most equipment. Non-routine maintenance or cleaning will be conducted as needed . . The facility maintains an aggressive infection prevention and control program . The program includes . policies and procedures based on CDC guidance. The infection prevention and control program is discussed regularly by the QAA committee . and appropriate action taken as needed . A request was made to the facility on [DATE] at 9:35 a.m. for cleaning/deep cleaning documentation of the North hallway tub from June 2024 to present, and no documentation was received by the end of the survey. (continued on next page)

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	05/20/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A request was made to the facility on [DATE] at 1:00 p.m. for housekeeping audits of cleaning and disinfecting practices, and no documentation was received by the end of the survey.