

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Valle Vista Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 (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
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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. Based on observation, interview, and record review, the facility failed to develop and maintain a comprehensive care plan, which included the presence of a resident's hearing aids and the need for staff to assist the resident with putting the hearing aids in his ears, for 1 (#6) of 18 sampled residents. Findings include: During an observation and interview on 6/2/26 at 10:50 a.m., resident #6 was lying in bed, not wearing his hearing aids. When asked why he was not wearing his hearing aids, the resident stated he was not sure where they were. Resident #6 stated he thought they may have been missing for approximately six months. The charger for resident #6's hearing aids was plugged in and sitting on the bedside table next to the sink in the resident's room. One hearing aid was found charging. During an observation and interview on 6/2/26 at 11:06 a.m., staff member X was asked about #6's hearing aids. Staff member X stated there was one in the charger, and he will have to ask the nurse if she knows where the other one was located. Staff member X returned to resident #6's room and stated the nurse did not know anything about the missing hearing aid. During an interview on 6/2/26 at 2:20 p.m., NF6 stated resident #6 had two hearing aids but was not able to put them in by himself. NF6 also stated that resident #6 was not good at asking for help. During an observation and interview on 6/3/26 at 9:39 a.m., resident #6 was lying in bed and did not have either of the hearing aids in place. There were no hearing aids in the charger, which was plugged in next to the sink in resident #6's room. During an interview on 6/3/26 at 9:43 a.m., staff member R stated she believed resident #6's hearing aids had been missing since the first week he was at the facility. Resident #6 was admitted to the facility in December 2025. Review of resident #6's Inventory of Personal Effects, dated 12/8/25, showed under the section Hearing Aid: Right and Left were circled. The Make, Model, and Serial Number were blank on the form. Review of resident #6's current care plan, initiated on 12/11/25, failed to show the presence of hearing aids or the need for staff to assist the resident with putting them in daily.		

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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 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. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide the needed assistance with completing Activities of Daily Living (ADL's) for 1 (#6) of 18 sampled residents. The deficient practice resulted in a resident not wearing his hearing aids or dentures. Findings include: During an observation and interview on 6/2/26 at 10:50 a.m., resident #6 stated he had upper and lower dentures, but was not sure where they were. Resident #6 was not wearing any dentures or hearing aids at the time of the observation. During an observation and interview on 6/3/26 at 9:39 a.m., resident #6 stated the staff did not offer to put in the resident's dentures or hearing aids. Resident #6 stated he needed help but did not like asking for help. The resident's upper and lower dentures were in a dry denture cup on the sink; the dentures were not in any water or cleanser. The upper denture had a dried pink substance on it. The hearing aid charger was on the nightstand next to the sink in the resident's room. There were no hearing aids in the charger. During an interview on 6/3/26 at 9:43 a.m., staff member R stated she had helped resident #6 with his morning cares and did not know the resident had dentures. Staff member R did not offer to assist the resident with his dentures or his hearing aids. Review of resident #6's Inventory of Personal Effects, dated 12/8/25, showed the resident had upper and lower dentures and two hearing aids. Review of resident #6's Quarterly MDS assessment, with an ARD of 5/6/26, showed the resident required substantial to maximal assistance with oral care and personal hygiene.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide a resident with necessary respiratory care and services as per physician orders and failed to ensure a portable oxygen tank was replaced when the metered volume indicated empty for 2 (#s 36 and 54) of 19 sampled and supplemental residents for oxygen therapy. This deficient practice increased the risk of negative outcomes stemming from respiratory complications due to a lack of provision of oxygen. Findings include:1. During an observation and interview on 6/2/26 at 3:36 p.m., resident #36 was sitting in her room watching television. Resident #36 was wearing oxygen via nasal cannula which was attached to a portable oxygen tank on the back of her wheelchair. The oxygen was set at two liters of oxygen, but the metered volume on the oxygen tank showed the oxygen tank as empty. When staff member N checked resident #36's oxygen saturation level, it showed at 87%. Staff member N said resident #36 was usually on two liters to keep her oxygen level above 90%.During an observation on 6/3/26 at 3:00 p.m., resident #36 was sitting in the dining room in her wheelchair. The metered volume on the oxygen tank showed the portable oxygen tank was empty.Review of resident #36's physician order, dated 3/26/24, showed resident #36 was to use three liters of oxygen per minute per nasal cannula to keep her oxygen saturation level over 90%.Review of resident #36's care plan showed the resident had heart failure and chronic obstructive pulmonary disease. The care plan directed the staff to administer oxygen.2. During an observation and interview on 6/3/26 at 2:55 p.m., resident #54 was sitting in her wheelchair in her room. Resident #54's oxygen tank was set at two liters; however, the oxygen tank was empty. Staff member J said she wore oxygen for comfort. Staff member J checked resident #54's oxygen saturation level and it was 88%. Resident #54 was agitated and swatted at the nurse attempting to take her oxygen saturation level.Review of resident #54's physician order, dated 4/14/26, showed resident #54 was to receive oxygen at two to four liters per minute to keep her oxygen level above 90%. This was to be done every shift related to chronic respiratory failure with hypoxia.		

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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.		