STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure a resident's right to a dignified existence for 1 (#8) of 3 sampled residents. The failure exposed the resident to feelings of embarrassment and shame associated with incontinence. Findings include:Review of a Facility-Reported Incident which occurred on 3/13/26 and was submitted to the State Survey Agency on 3/17/26, showed that while attending a group activity, resident #8 had an episode of incontinence and had to leave the activity so she could be cleaned up. The report showed NF1 had announced loudly, and in front of other residents and staff, that there was a big mess needing to be cleaned up, referencing the resident's situation. During an interview on 6/30/26 at 1:27 p.m., staff member D stated she had received a verbal report from staff member E alleging NF1 had been picking on resident #8, and the resident became so upset she was incontinent of stool during the activity and had to be removed from the activity to receive care for the incontinent episode. During an interview on 6/30/26 at 3:15 p.m., staff member C stated she usually handled incidents involving staff behavior and discipline. Staff member C reported she had spoken to staff member E, who had initially reported the incident, and to NF1, the staff member who had been accused of mistreating resident #8. Staff member C stated that after speaking with staff who witnessed the incident and reviewing the documentation for the incident, she determined there was no malicious intent on the part of NF1. Staff member C, in consultation with staff member B, determined the incident involved resident dignity and resident rights rather than actual resident abuse. Because NF1 had been an employee for many years and did not have any disciplinary write-ups in her personnel file, the decision was made to do a written disciplinary warning and additional education instead of termination for the staff member. Staff member C stated NF1 refused to sign the disciplinary write-up and resigned from her position. Staff member C stated that NF1 did admit to feeling frustrated when caring for resident #8, due to the resident's intellectual disability. During an interview on 7/1/26 at 10:30 a.m., staff member B stated he did not feel the incident rose to the level of abuse because the accused, NF1, was only trying to get the attention of someone to assist the resident and did not identify the resident by name. Staff member B also stated NF1 did not specify the type of mess needing to be cleaned up.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interview and record review, the facility violated a resident's right to privacy during incontinence care when, during direct care and in the presence of the resident, a caregiver used her personal cell phone to discuss a resident's care with someone who was not a staff member of the facility for 1 (#7) of 3 residents sampled for abuse by facility staff. The failure involved allowing an unauthorized person, not employed by the facility, to be present via telephone during incontinence care. Findings include:Review of a Facility-Reported Incident which occurred on 8/3/25 and was submitted to the State Survey Agency on 8/4/25, showed NF2 was alleged to have used her personal cell phone to contact a CNA regarding how to handle resident #7's resistance to care. As part of the investigation of the incident, NF2 was found to have contacted her family member, who was a CNA but was not employed by the facility. The call was made while personal care was being provided to resident #7, who had an episode of bowel incontinence. NF2 was immediately suspended pending investigation of the allegation.During an interview on 6/29/26 at 9:47 a.m., staff member K stated resident #7 was independent with her ADLs except toileting. Staff member K stated if abuse was alleged, the DON was notified immediately.Review of NF4's written statement, dated 8/4/25, showed she observed NF2 on the phone with someone while performing incontinence care for resident #7. NF4's written statement showed it was a video call because she could see the camera was on. When NF2 was asked what she was doing by NF4, NF2 stated, It's ok, He is a CNA. NF4's statement also showed, [NF2] turned the camera towards [Resident #7's] bottom (buttocks area) and the mess all over the floor.Review of NF2's interview, dated 8/4/25, showed NF2 did call someone to ask for advice on how to care for someone resistant to care. The person on the phone was a CNA who was not employed by the facility. NF2 denied the call was a video call.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the resident's right to be free from physical and verbal abuse by a staff member for 1 (#7) of 3 residents sampled for abuse by facility staff. During the survey, it was found the facility had previously identified, investigated, and corrected the non-compliance for abuse by a staff member. Findings include:Review of a Facility-Reported Incident, which occurred on 8/3/25 and was submitted to the State Survey Agency on 8/4/25, showed NF2 was alleged to have yelled at resident #7 because she had a bowel movement during an activity session. NF2 continued to complain about the resident's incontinent episode, in front of resident #7, about how far behind she was because of the mess resident #7 made.Review of the investigative file for the incident showed the facility gathered the following written statements associated with the incident: - Staff member G, dated 8/3/25, stated [NF2] was going off about how big of a mess it was and how gross it was in front of [Resident #7]. And . I heard [Resident #7] screaming. So I went to [Resident #7's] room . and seen [Resident #7] sitting in her wheel chair with no pants on and no brief. BM was all over the walls in the bathroom . [NF2] went off again about [Resident #7] . [sic]- NF2's written statement, dated 8/4/25, showed she found resident #7 falling out of her chair, and she used a Hoyer (mechanical) lift to get the resident into a shower chair to be cleaned up. The statement did not contain information showing anyone heard NF2's verbal statements during the activity session referencing how big and gross the mess was for resident #7. - NF2's written interview, dated 8/4/25, showed resident #7 was incontinent several times during the shift, and the resident became resistive to the care being offered. NF2 stated she did leave resident #7 in her room without a brief or pants. NF2 denied that her conversation with resident #7 was inappropriate. NF2 stated she called her family member, who was a CNA at another facility, to ask for advice on how to handle a resident who was resistant to care. NF2 denied the call was a video call. NF2 did state she was frustrated with the nurse, but not with resident #7.Review of resident #7's nursing progress note, dated 8/3/25, showed the resident was, . hanging off of her w/c and almost to the floor. Used hoyer lift to get up off the floor and into a shower chair. Elder (the resident) needed a shower due to having diarrhea. [sic]During an interview on 6/29/25 at 9:47 a.m., staff member K stated resident #7 was independent with her ADLs except for toileting. Staff member K stated she had received abuse reporting education after the incident, and if abuse was alleged, it was to be reported to the supervisor or the DON immediately.During an interview on 7/1/26 at 10:30 a.m., staff member B stated all of the residents in the cottage were asked about similar treatment by NF2. All of the residents, except resident #7, denied any mistreatment by NF2. NF2 was terminated at the conclusion of the investigation. Staff member B stated that abuse identification and reporting education was provided on 8/14/25 and the incident was discussed in the QAPI meeting on 8/29/25.Review of the facility's investigative file showed the facility immediately suspended the alleged staff member (NF2). Resident #7 was assessed and found to have no injuries. The other 11 residents in the cottage were interviewed and none had complaints about the care received from NF2. Resident #7's provider and representative were notified when the abuse was substantiated and NF2 was terminated. Staff education occurred on 8/14/25 and QAPI involvement occurred on 8/29/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident from misappropriation of resident property in the form of missing medication for 1 (#9) of 3 sampled residents. The failure increased the risk of the resident not having enough medication to adequately manage her anxiety. Findings include:Review of a Facility-Reported Incident for an event that occurred on 4/3/26, which was submitted as misappropriation of property, was sent to the State Survey Agency on 4/6/26. The report showed that two unlabeled syringes were found in the medication cart located at [NAME] Cottage. A review of the video surveillance in the cottage showed NF3 had placed the two syringes in the medication cart on the morning of 4/2/26. One of the syringes contained 0.4 ml of a clear liquid determined to be oral lorazepam. The second syringe contained a trace amount of a red liquid determined to be oral morphine sulfate. The only open bottle of lorazepam belonged to resident #9; a resident residing at the [NAME] Cottage. The open bottle of lorazepam and the narcotic sign-out sheet were taken to the pharmacy. The measured amount in the bottle of lorazepam was 23.5 ml. The narcotic sign-out sheet showed there should have been 26 ml; a difference of two and a half ml. At the conclusion of the investigation, NF3 was terminated for the substantiated misappropriation of property, and the local law enforcement and the State Board of Nursing were notified of the missing narcotic medication and misappropriation by staff member NF3.During an observation and interview on 6/30/26 at 2:03 p.m., staff member J demonstrated the process for dispensing, administering, and documenting oral lorazepam to a resident. A 30 ml syringe containing 15 ml of oral lorazepam (2 mg per ml strength) was removed from the locked refrigerator. A one ml syringe with markings at each 0.02 ml was filled with 0.25 ml of lorazepam oral liquid. Staff member J then documented on the narcotic sign-out sheet the amount to be given to a resident (0.25 ml). The amount taken (0.25 ml) was subtracted from the total amount (15 ml), and the amount of the medication remaining on the narcotic sign-out sheet was documented as 14.75 ml.During an interview on 7/1/26 at 12:16 p.m., staff member B described the sequence of events involved in the medication diversion and misappropriation of the resident's property. Staff member M was passing medications in [NAME] Cottage. At approximately 12:30 p.m., staff member M found two unlabeled syringes in the medication cart. Staff member M immediately reported this to staff member B. The unlabeled medication in the syringes was determined by the pharmacy to be oral lorazepam and oral morphine sulfate. The only open bottle of oral lorazepam had been dispensed to resident #9. Surveillance videos in both [NAME] and [NAME] Cottages were reviewed, and NF3 was identified as the staff member who placed the syringes in the [NAME] Cottage medication cart. The misappropriation of resident medication (property) was substantiated, and NF3 was terminated from the position at the facility. Review of the facility's policy titled Controlled Substances Recordkeeping, dated November of 2022, showed the following: - [Facility Name] strives to provide that every dose of a controlled substance is securely stored and accounted for.- [Facility Name] Nursing. B. Records on Controlled Substance Reconciliation Count Sheet each time a Controlled Substance medication dose is administered.C. Verifies counts of each Controlled Substance medication at the end of each shift and signs the Controlled substance Tracking Form.1. Any discrepancy in the controlled substance count will be reported to the member of nursing administration before the off-going nurse is dismissed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 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. Based on interview and record review, the facility failed to report an allegation of resident abuse in a timely manner for 1 (#8) of 5 residents sampled for timeliness of reporting abuse allegations. Findings include:Review of a Facility-Reported Incident for an event that occurred on 3/13/26 was submitted to the State Survey Agency on 3/17/26 and showed that an allegation of resident abuse was made by staff member E.During an interview on 6/30/26 at 1:27 p.m., staff member D stated she received a verbal report of an abuse allegation involving resident #8 and NF1. Staff member D stated she was new to her position, so she was not aware of the need to report allegations of abuse within 24 hours of the incident. Staff member D stated she took notes while interviewing staff member H on 3/13/26. Staff member D also spoke with staff member E regarding what she witnessed. Staff member D stated she received an email from her supervisor on Monday, 3/16/26, regarding the reporting timeframes for reportable events. Staff member D stated she was now aware that a reportable event needed to be reported within 24 hours of the incident.During an interview on 7/1/26 at 10:30 a.m., staff member B stated he knew the abuse allegation was reported late.Review of the facility's policy titled Abuse, dated August of 2022, showed, Abuse is reported no later than 24 hours after the allegation is made ., to the Director of Nursing or designee of the facility and to other officials (including to the State Survey Agency .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 nursing staff failed to meet professional standards of quality by not ensuring all controlled substance medications were accurately accounted for and documented in a resident's EHR, for 3 (#s 2, 6, and 9) of 3 sampled residents for controlled substance medications. This deficient practice affected the accuracy of medication administration records, had the potential to result in administration errors, and to allow unidentified controlled substance diversion to occur. Findings include:1. Review of resident #9's MAR and narcotic sign-out showed the following discrepancies:- MAR, 3/30/26, 0.5 ml at 9:33 a.m., narcotic sign out 3/30/26, 0.25 ml at 9:00 a.m.,- MAR, 4/1/26, none, narcotic sign out 4/1/26, 0.5 ml at 7:15 p.m. and at 9:00 p.m. 2. Review of resident #2's MAR and narcotic sign-out showed the following discrepancies:- [DATE]/11/26 0.25 ml at 5:00 p.m., narcotic sign out none,- [DATE]/17/26 0.25 ml at 8:00 a.m., narcotic sign out none 3. Review of resident #6's MAR and narcotic sign-out showed the following discrepancies: - MAR, 1/22/26 none, narcotic sign out 1/22/26 0.5 ml at 2:00 p.m. and 7:10 p.m.- [DATE]/23/26 sleeping at 9:00 a.m., not given, narcotic sign out 0.5 ml at 10:37 a.m., and- [DATE]/26/26 none, narcotic sign out 1/26/26 0.5 ml at 3:00 a.m. During an interview on 6/30/26 at 2:03 p.m., staff member J stated that the MAR documentation and the narcotic sign-out sheet should match. Staff member J stated that any discrepancies needed to be reported. Staff member J stated she had seen instances where the medication was signed out from the locked medication cart and not documented on the resident's MAR and instances where the medication was signed out on the MAR without a corresponding entry on the narcotic sign-out sheet. During an interview on 7/1/26 at 10:30 a.m., staff member B stated that the facility's expectation was that every dose of a narcotic (controlled substance) needed to be documented on both the narcotic sign-out sheet and the resident's MAR, and this was the standard of practice for medication administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275024	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Lutheran Home	3940 Rimrock Rd Billings, MT 59102

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a system that accurately recorded, monitored, and reconciled the accuracy of dispensing lorazepam oral liquid for 1 (#9) of 3 sampled residents for use of controlled substance medications. The deficient practice resulted in a discrepancy between the number of doses removed from secure storage and the number of doses administered to a resident. Findings include:Review of a Facility-Reported Incident for an event that occurred on 4/3/26 was submitted to the State Survey Agency on 4/6/26. The document showed that two unlabeled syringes were found in the medication cart in [NAME] Cottage. One of the syringes contained 0.4 ml of a clear liquid determined to be oral lorazepam. The second syringe contained a trace amount of a red liquid determined to be oral morphine sulfate. The open bottle of lorazepam and the narcotic sign-out sheet were taken to the pharmacy. The measured amount in the bottle of lorazepam was 23.5 ml. The narcotic sign-out sheet showed there should have been 26 ml, a difference of two and a half ml. Refer to F602 - Misappropriation of Property, related to the diversion of a controlled substance medication.During an interview on 7/1/26 at 12:16 p.m., staff member B described the usual process for dispensing, storing, and destroying lorazepam oral liquid. The lorazepam liquid was dispensed in a 30 ml bottle. Each time a dose was removed and administered to a resident, the amount removed was subtracted from the amount on hand, and the amount remaining was documented. The amount remaining was transferred to the next line and documented in the amount on hand column. This process was done for each dose of medication. When the resident is no longer receiving the medication, the amount in the bottle is measured and should match the amount remaining. Staff member B stated that the process for dispensing controlled substance medications was changed when the medication diversion was identified in April of 2026. Staff member B stated the lorazepam oral liquid was no longer dispensed in a brown multidose bottle. It was being dispensed as 15 ml in a 30 ml syringe. Review of a pharmacy audit, dated 3/31/26, showed there were several discrepancies with controlled substances, including two bottles of lorazepam oral liquid.Review of a pharmacy audit, dated 5/21/26, failed to identify discrepancies in the dispensing and administration of lorazepam oral liquid. One of the audits monitored each of the four long-term care cottages, identifying discrepancies in the accurate completion of the controlled substance sign-out sheets. Although the accuracy of some controlled substances was monitored, there was nothing regarding the accuracy of lorazepam oral liquid.Review of the facility's policy titled, Controlled Substances Recordkeeping, dated November of 2022, showed the following: - [Facility Name] strives to provide that every dose of a controlled substance is securely stored and accounted for.- [Facility Name] Nursing.B. Records on Controlled substance Reconciliation Count Sheet each time a Controlled Substance medication dose is administered.C. Verifies counts of each Controlled Substance medication at the end of each shift and signs the Controlled substance Tracking Form.1. Any discrepancy in the controlled substance count will be reported to the member of nursing administration before the off-going nurse is dismissed.