STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275043	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health & Rehabilitation	2651 South Ave W Missoula, MT 59804

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 interview and record review, the facility failed to provide prompt physician notification for a resident who sustained a fall resulting in injury with pain for 1 (#85) of 34 sampled residents. This deficient practice contributed to a delay in treatment, and the resident was found to have a fracture. Findings include:During an interview on 8/26/25 at 9:36 a.m., resident #85 explained that she was admitted to the facility in July after she developed complications from a right hip replacement. Resident #85 stated she had a fall when her leg got caught during a transfer, and she fell because the nurse went to get help and left her standing at the edge of the bed with nothing to hold on to. During an interview on 8/27/25 at 9:48 a.m., staff member O stated the fall protocol was to notify the family, the physician, and write up a fall report. Staff member O stated he did not notify the physician on call after resident #85 fell. Staff member O stated resident #85's care was delayed by a couple of hours.During an interview on 8/27/25 at 2:54 p.m., staff member B stated the fall protocol was to notify everyone of the fall, including the family and the doctor.Review of resident #85's EHR, showed a documentation note, dated 8/9/25 at 3:07 p.m., and the note failed to show the physician was notified of the resident's fall and increased pain.Review of resident #85's EHR showed a Secure Conversations note, dated 8/11/25 at 1:54 p.m., which included, Messages: Subject ED transfer . [8/9/25 22:45 PM] (10:45 p.m.) . she (resident #85) reports intolerable pain 10/10 above her R knee. Pain becomes worse if R leg is moved or R knee is bent, very tender to touch and unable to use it for support. R leg looks like a little bent/twisted out of shape going inward . At around 1940H (7:40 p.m.), called on call provider [provider on call], to send to ED .During an interview on 8/28/25 at 9:45 a.m., staff member A questioned this surveyor about a document that was provided by the facility, which showed the provider was notified about the fall at the time of the event. This surveyor clarified for staff member A that staff member O stated he did not notify the physician on call after resident #85 fell.Review of the facility document titled Notification of Changes, last review date of 10/14/24, showed: Policy: The facility will inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or appropriate family members(s) of the following:1. An accident resulting in injury to the resident that potentially requires physician intervention. 2. A significant change in the physical, mental, or psychosocial status of the resident. Policy Explanation and Compliance Guidelines:1. In the case of a competent resident, the facility will contact the resident's physician and appropriate family member(s) .5. Document in the resident's clinical record the date and time of the notification. Review of the facility's document titled Fall Prevention Program, last review date 1/23/25, showed: . 5. When a resident experiences a fall, the facility will:.d. Notify physician and family. The delay of physician notification impacted the physician's opportunity to provide directives on the resident's care, pain, and injury.

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 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 the interview and record review, the facility failed to report allegations of resident abuse to the State Survey Agency within 24 hours of an incident for 2 (#s 99 and 129) of 5 residents sampled for Facility Reported Incidents. Findings include:Review of the facility reported incident dated 6/27/25 at 8:15 p.m., showed resident #99 and resident #129 were involved in a physical altercation. Resident #99 reported to the nurse resident #129 grabbed resident #99's groin. The initial allegation of resident-to-resident abuse was not received by the State Survey Agency until 6/30/25.During an interview on 8/27/25 at 11:22 a.m., staff member A stated she was not aware the facility failed to report the allegations of resident-to-resident abuse to the State Survey Agency within 24 hours for the facility reported incident which occurred on 6/27/25, involving residents #99 and #129. Staff member A stated the facility's video surveillance of the incident was no longer available for review. During an interview on 8/28/25 at 8:52 a.m., staff members A and C were present. Staff member C stated the incident involving residents #99 and #129, on 6/27/25, was not reported to the State Survey Agency within 24 hours because resident #99 denied that the incident occurred. Staff member C stated resident #99 met with and reported to social services on 6/30/25 resident #129 touched resident #99's groin area on 6/27/25. Staff member C stated the facility then reported the incident to the State Survey Agency. Review of resident #99's nursing progress note, dated 6/28/25 at 5:21 a.m., showed resident #99 went to the nursing station on 6/27/25 at 8:13 p.m. and reported that resident #129 had touched his groin. Resident #99 was ambulating in his wheelchair, from the 700 hall, back to the nursing station. When doing so, resident #99 passed resident #129, and resident #129 had his head down looking at the rug, and he was swinging his hands down. The nursing progress note showed resident #129 stated he wasn't paying attention, and it was an accident (touching #99 on groin). Resident #99 calmed down and seemed to accept the actions of resident #129 were not on purpose. A message was sent to social services and nursing, and a text message was sent to the director of nursing, to make them all aware of the incident. Review of the facility's policy titled, ABUSE, NEGLECT AND EXPLOITATION, last revision dated 1/11/25, showed: 1. Definitions. Sexual Abuse is non-consensual sexual contact of any type with a resident. V. Identification of Abuse, Neglect, Exploitation and MisappropriationThe facility will identify factors indicating possible abuse, neglect, exploitation of residents, or misappropriation of resident property, including, but not limited to, the following possible indicators:-Resident, staff or family report of abuse; . VII. Response and Reporting of Abuse, Neglect, Exploitation, and MisappropriationAnyone with knowledge or concerns about the care of a resident in the facility must report suspected abuse to the Facility administrator, abuse agency hotline or file a complaint with the state survey agency and adult protective services (if applicable under state law) immediately (but not later than 2 hours after an allegation is made if the events that lead to the allegation involve abuse or result in serious bodily injury) or not later than 24 hours if the events that lead to the allegation do not involve abuse and do not result in serious bodily injury. Reporting and investigation should be in accordance with state law/regulation.When abuse, neglect or exploitation is suspected, the Administrator or designee should:. Contact the state agency and the local Ombudsman office to report the alleged abuse; . [sic]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from accidents for a resident who sustained a fall with pain resulting in a fracture, who was on a blood thinner; and failed to promptly notify the physician of a fall with pain resulting in a fracture impacting the physician's opportunity to determine if a higher level of care or treatment was necessary at the time of the fall for 1 (#85) of 34 sampled residents. This deficient practice contributed to delayed care, increased pain and a femur fracture.During an interview on 8/26/25 at 9:36 a.m., resident #85 explained that she was admitted to the facility in July after she developed complications from a right hip replacement. Resident #85 stated she had a fall when her leg got caught during a transfer, and she fell because the nurse went to get help and left her standing at the edge of the bed with nothing to hold on to. Resident #85 said the nurse who was on told a bunch of CNAs to say I wouldn't allow them help me. Resident #85 stated, There was nobody in the room and that's the truth. During an interview on 8/27/25 at 9:48 a.m., Staff member O stated he was in resident #85's room on the day of the fall to assist resident #85 with a dressing change. Staff member O stated resident #85 transferred with a walker and a one-person assist and was 50% weight bearing on the right leg. Staff member O said resident #85 liked to push the wheelchair to transfer. Staff member O stated resident #85 was choosing to use the wheelchair to transfer, and he asked the resident to please be extra careful. Staff member O stated the resident fell when moving from the bed to the recliner. Staff member O stated that resident #19 fell with him trying to slow her, stating, I had some influence. Staff member O stated the resident was reporting pain in her right knee at the time of the fall. Staff member O stated he did not notify the physician on call after the resident fell, and her care was delayed by a couple of hours. Staff member O reported the resident did not want to go to the emergency room. Staff member O stated he didn't realize there were other required reports to complete at the time of the fall, such as the incident and risk management charting. Staff member O stated he felt like he did not know how to do a lot of things at the facility and said, I had to fight tooth and nail to get any orientation here. I still don't feel fully enabled on how to do my job. Review of resident #85's EHR showed a clinical note, dated 8/9/25 at 5:12 p.m., Note Text: While ambulating from the bed to the recliner with a wheel chair she lost her balance and I gently helped her to the ground to sit on her butt. Her right lower leg bent at the knee and was under her L leg. It caused her pain so I helped her straighten it. Then with the help of a CNA we got her to standing and had her sit in the recliner. A while later she stated being unable to put weight on it. The pain is in her popliteal fossa. I asked her if she wanted me to send her to the ED. She does not want to go. Treated with Robaxin, oxycodone and ice after the incident. The plan to continue the same pain management for the night and if it's not better by morning send her to the ED. During an interview on 8/27/25 at 10:30 a.m., NF5 stated she was the nurse attending to resident #85 upon admission to the emergency room, on the day after resident #85's fall. NF5 stated she had concerns because the EMT who gave her a summary stated there was a different story from what the resident reported and what the facility staff reported. NF5 stated resident #85 had fallen earlier in the day and presented with her right leg internally rotated and significantly shorter than the left leg, which were indications of a broken extremity. NF5 asked resident #85 why her care was delayed and asked the resident if her leg always looked like that. NF5 stated the resident reported the nurse at the facility had advised the resident to wait to see if it was worse in the morning before transferring to the emergency department. This statement contradicts the statement from staff member O who said she did not want to go to the ER. During an interview on 8/27/25 at 3:29 p.m., resident #85 stated staff member O stated he was going to put ice on her right leg, wait until the morning, and if it (leg) was swelled up she would be sent to the ER. Resident #85 stated she did not decline transfer to the ER at the time of the event. Resident #85 stated she went by what staff member O advised, to wait until the morning, and his comment about We'll see in the morning.During an interview on 8/28/25 at 9:45 a.m., staff member A questioned this surveyor about a document that was provided by the facility, which showed the provider was notified about the fall at the time of the event. This surveyor clarified for staff member A that staff member O stated he did not notify the physician on call after resident #85 fell. Therefore, the document provided was not accurate for the physician notification. Review of resident #85's Comprehensive MDS assessment, with an ARD of 7/14/25, showed resident #85 had a BIMS score of 14, cognitively intact.Review of resident #85's EHR, showed a progress note, dated 8/9/25 at 3:07 p.m., which included, Note Text: Reason for note: Initial note (immediately after the fall). I was with her as she was using the back of her