

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/29/2026
NAME OF PROVIDER OR SUPPLIER Livingston Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 510 S 14th St Livingston, MT 59047	
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 neglect for a resident who was dependent upon staff for incontinence care, resulting in the resident not receiving the necessary incontinence care for an extended period. The failure placed the resident at risk for skin breakdown, infection, pain, discomfort, loss of dignity, and psychosocial distress, for 1 (#18) of 7 residents sampled for abuse and neglect. Findings include: Review of a Facility-Reported Incident submitted to the State Survey Agency on 6/2/26 showed an allegation of neglect involving resident #18. The report alleged resident #18 remained soiled throughout an entire shift after required incontinence care was not provided. The facility's investigation findings showed, Although the resident did not voice concerns about the care, nine staff interviewed indicated the employee was not completing assigned duties. The employee provided a statement indicating he did not provide care for the resident. This employee was terminated on 6/5/26. During an interview on 6/27/26 at 2:50 p.m., resident #18 recalled the day staff member NF4 was assigned to provide care, stating, Of course I remember. That guy did not change me once. The last time I was cleaned up was by the night shift before they left. The other CNAs cleaned me up late in the afternoon. What a mess. During an interview on 6/28/26 at 9:33 a.m., staff member A stated resident #18 was hit and miss with using the call light, required care in pairs because of behaviors, and was almost continuously incontinent of urine. Staff member A stated the CNAs all knew resident #18 required changing every one-to-two-hours as she couldn't always tell she was wet, and often wouldn't call for help. Staff member A stated [NF4] did not provide the care for resident #18 as assigned. Staff member A stated NF4's employment was terminated shortly after the incident because of ongoing performance concerns and not exclusively due to the resident neglect. Staff member A stated written documentation of prior performance concerns or corrective actions for NF4 could not be located. During an interview on 6/28/26 at 1:40 p.m., staff member M stated she reported the incident on 6/2/26, after resident #18 pressed the call light and stated she had been left wet since the early morning. Staff member M stated resident #18 . was saturated head to toe. Staff member M stated the facility's CNAs typically made their own assignments and worked in teams and divided the facility into three team assignments. Although staff worked in teams, staff member M stated resident #18 was specifically assigned to NF4. Staff member M stated resident #18 required care in pairs, and another certified nursing assistant would have been required to assist NF4 with the resident's care. Staff member M stated resident #18 depended on staff to recognize and provide incontinence assistance as she had limited awareness of her incontinence at times. During an interview on 6/29/26 at 2:12 p.m., NF4 stated CNA assignments were not always clear, and responsibility for resident care was shared among team members. NF4 stated he was not assigned to resident #18's care on 6/2/26, but he was assisting in her hall. He requested assistance to provide resident #18's required care in pairs; however, the other certified nursing assistants were busy. NF4 stated another team eventually changed resident #18, after which he (the neglect of care) was reported to staff member A and later terminated. During an interview on 6/29/26 at 10:30 a.m., staff member B stated CNAs made their own assignments; some preferred to work individually while others worked in teams, and the current (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assignment process may have created opportunities for conflicts and missed care. Review of resident #18's care plan intervention, updated 12/3/25, showed, Care in pairs if indicated. Review of resident #18's CNA task list and Kardex showed the resident required care by two staff members as well as checks and incontinence care every one to two hours. Review of resident #18's electronic health record showed incontinence care was documented on 6/2/26 by staff member NF4 during the 9:00 a.m. hour and was not documented again until staff member M documented incontinence care during the 2:00 p.m. hour, despite resident #18's required every one-to-two-hour checks and incontinence care. The documentation contradicted staff member NF4's statement that he had not provided care to resident #18 on 6/2/26. Review of a facility policy titled Prevention of All types of Abuse, Neglect, Mistreatment, Involuntary Seclusion, and Misappropriation of Resident Property, updated October 2022, showed: . e. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as: i. Verbally abusive behavior .vii. Residents that require extensive nursing care .		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure thorough investigations of alleged abuse and neglect were completed for 2 (#s 10 and 50) of 7 residents sampled for abuse. This deficient practice could place other residents at risk for abuse and neglect. Findings include: A review of a Facility-Reported Incident submitted to the State Survey Agency on 6/15/26, showed resident #s 10 and 50 made abuse allegations against two different certified nurse assistants. The State Survey Agency event report for resident #50 showed an allegation of abuse and neglect. In the report, resident #50 stated staff member J was mean, rude, and rough when providing perineal care during the night. During an interview on 6/28/26 at 9:15 a.m., resident #50 stated that staff members J and O came into her room to provide care. Resident #50 stated staff member J told her she (the CNA) did not sign up to take care of that kind of mess (incontinent episode). Resident #50 stated staff member O provided care and did a good job. Resident #50 stated she called the certified nursing assistants to her room again at about 5:30 a.m. Resident #50 stated that staff members J and O both responded to the call light. Resident #50 stated staff member J rudely said, This better be your last time tonight (soiling self due to incontinent episode) because I'm clocking out and leaving. Resident #50 stated that these interactions with staff member J made her feel very apprehensive about when help is needed. Review of the facility's investigation file showed the allegation made by resident #50 was not investigated during the facility investigation process, as the complaint was made against staff member J, and staff member J was not interviewed.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure prescribed psychotropic medications were administered as ordered for 1 (#51) of 6 residents sampled for medication administration by failing to obtain prescribed medications and failing to notify the physician when the medications could not be administered. The failures placed the resident at risk for increased mental health symptoms and other adverse clinical outcomes associated with interruption of prescribed psychotropic medication therapy. Findings include: Review of a Facility-Reported Incident submitted to the State Survey Agency on 5/7/26 showed resident #51 was admitted on [DATE] with physician orders for psychotropic medications including Lithium ER 300 mg twice daily, Sertraline 25 mg daily, and Quetiapine 100 mg twice daily. The report showed the medications were not administered as ordered due to miscommunication between facility nursing staff and the pharmacy. During a telephone interview on 6/29/26 at 9:00 a.m., staff member R stated she recalled the incident and understood the medications for resident #51 were unavailable because of some confusion with the pharmacy. Staff member R stated she was not sure how to access the list of medications available through the facility's stocked prescription medication dispensing system. Staff member R could not recall whether she had received education regarding the medication dispensing system or the facility's policy for missed medications. During an interview on 6/29/26 at 4:15 p.m., staff member A discussed the facility's investigative documents and stated the facility's investigation determined that miscommunication and misinterpretation of the facility policies and procedures contributed to the deficient practice. Staff member A stated nursing staff did not follow up on medications ordered from the pharmacy, determine whether the medications were available through the facility's stocked prescription medication system, notify the physician when ordered medications could not be administered, or document actions taken to ensure continuity of medication therapy. Staff member A stated the previous Director of Nursing implemented corrective measures and auditing; however, documentation of those actions could not be located. Review of resident #51's medication admission orders showed the resident was prescribed the following psychotropic medications: -Lithium ER 300 mg by mouth twice daily, -Sertraline 25 mg by mouth once daily, and -Quetiapine 100 mg by mouth twice daily. Review of resident #51's Medication Administration Record for May 2026 showed: -Lithium ER 300 mg, scheduled for 8:00 a.m. and 8:00 p.m. daily beginning at 8:00 p.m. on 5/5/26, and this was documented as not administered on 5/5/26, 5/6/26, and 5/7/26, resulting in four missed doses. -Sertraline 25 mg, scheduled for 8:00 a.m. daily beginning on 5/6/26, was documented as not administered on 5/6/26 and 5/7/26, resulting in two missed doses. -Quetiapine 100 mg, scheduled for 8:00 a.m. and 8:00 p.m. daily beginning at 8:00 p.m. on 5/5/26, was documented as not administered on 5/7/26, resulting in one missed dose. Review of resident #51's nursing progress notes for the 48-hour period from 5/5/26 through 5/7/26 corresponding to the missed medication doses showed entries which included, on order, waiting on pharmacy, and waiting on pharmacy to sent. [sic] The nursing progress notes did not show documentation of follow-up with the pharmacy regarding the unavailable medications, attempts to obtain the medications through the facility's stocked prescription medication dispensing system, or notification to the physician after resident #51 missed consecutive doses of prescribed psychotropic medications. Review of a facility policy titled Medication Administration, dated 1/2024, showed, . If two consecutive doses of a vital medication are withheld or refused, the physician is notified. Review of a facility policy titled Psychoactive Medications, dated 6/2025, showed, . It is the policy of this facility that the resident's medication regimen . helps to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being .		