

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

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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 0880 Level of Harm - Actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and maintain a water management program for the prevention of waterborne pathogens in accordance with CDC guidance for 1 (#6) of 20 sampled and supplemental residents. Environmental testing identified Legionella bacteria within the facility's water system after resident #6 was diagnosed with Legionnaires' disease. The facility's failure to implement and maintain its water management program placed all residents at increased risk for exposure to waterborne pathogens. During the survey, it was found that the facility had previously identified, investigated, and corrected the non-compliance for the water management system, resulting in findings of Past Non-Compliance. Findings include: During an interview on 6/28/26 at 5:15 p.m., staff member G stated he had worked at the facility for approximately one year and had learned the facility's water management activities on the job. Staff member G stated the facility's Legionella prevention measures included weekly flushing of toilets in unoccupied resident rooms and weekly water temperature monitoring throughout the facility. Staff member G stated a resident became ill in March 2026 and was subsequently diagnosed with Legionnaires' disease. During an interview on 6/29/26 at 7:34 a.m., staff member A stated the facility was notified on 3/18/26 that resident #6 tested positive for Legionella. Staff member A stated the facility had been flushing areas at risk for water stagnation; however, the facility's water management practices were not following public health guidelines. Staff member A stated the facility subsequently contacted the local public health department for guidance. Review of resident #6's provider note, dated 4/1/26, showed resident #6 was hospitalized on [DATE] with acute hypoxic respiratory failure related to Legionnaires' disease. Corrective Measures Review of facility's maintenance documentation showed the facility obtained consultation from NF5, NF6, and NF7 between 3/19/26 and 3/31/26 to evaluate the building water system and provide recommendations to reduce the risk of Legionella. The facility revised its water management program based on current public health guidance, implemented ongoing environmental water monitoring, and provided staff education regarding the revised procedures. Review of the facility's QAPI meeting minutes dated 3/25/26 through 5/19/26 showed the committee monitored implementation of the revised water management program, reviewed environmental testing results, and discussed ongoing monitoring activities. Review of the facility's environmental testing records showed follow-up water samples collected through 5/12/26 were negative for Legionella. The surveyor determined the facility completed corrective actions before the survey, implemented its revised water management program, and maintained ongoing environmental monitoring. Follow-up environmental testing remained negative for Legionella, verifying the findings of Past Non-Compliance, as the deficient practice had been corrected prior to the survey.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 275047	Facility ID: 275047 If continuation sheet Page 1 of 6

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation, and taste testing of food served by the facility, the facility failed to provide food at a palatable and appetizing temperature for 5 (#s 14, 28, 40, 48, and 52) of 20 sampled and supplemental residents. This deficient practice affected the residents' nutrition, weight management, and quality of life. Findings include: During an observation and interview on 6/27/26 at 12:31 p.m., resident #52's food was placed uncovered on the dining room table. Resident #52 got to the dining room and began eating at 12:36 p.m. When asked if his food was hot, resident #52 said no, not his French fries. During an observation and interview on 6/27/26 at 12:42 p.m., resident #48 was observed sitting at the dining room table. A staff member was observed bringing resident #48's food tray into the dining room from down the hall toward the E hall nurses station. Resident #48 stated, no, my food was not hot. She was served a Philly cheesesteak sandwich and French fries. During an interview and observation on 6/27/26 at 1:14 p.m., resident #28's food tray was sitting on her bedside table. She had been served French fries and a Philly cheesesteak sandwich. Resident #28, said no, her food wasn't hot today and was often not hot. She said, I eat what I can, but it does prevent me from eating well. During an interview on 6/27/26 at 1:32 p.m. resident #40 stated she knew she could ask for other food or it heated up, but she did not want to inconvenience the staff. Resident #40 said the French fries were cold today and when eggs are served for breakfast, the eggs are always cold. During an interview on 6/27/26 at 2:58 p.m., resident #14 said the food was usually cold by the time it was delivered to her room. Resident #14 said if she doesn't like the food or the food was too cold, she just does not eat it. Resident #14 said she had lost weight in the last six months and she said weight loss was partly due to the food served and partly her choice to lose weight. During observation and an interview on 6/28/26 at 7:32 a.m., the meal cart for the 200 rooms left the kitchen. A meal tray was requested for a sample, with the tray to be the last served from the kitchen and the last delivered off the cart. Between 7:32 a.m. and 8:01 a.m., the food delivery cart was noted to have the doors open and closed many times. The tray was delivered to the conference room at 8:01 a.m. by staff member P. The meal consisted of a bowl of oatmeal with a scoop of brown sugar, one fried egg, and a factory-wrapped blueberry muffin. The oatmeal tasted hot and appetizing. The fried egg was cold and was not appetizing. Staff member P said she was aware some residents had complained about cold food. During an interview on 6/28/26 at 11:25 a.m., staff member H said she was aware there had been some cold food complaints. During an observation and interview on 6/28/26 at 1:06 p.m., staff members K and M brought a sample tray to the conference room. The food was cabbage, pork roast, roasted potatoes, and corn bread. The food was sampled and the temperature of all the food was barely warm to the taste. Both staff members K and M said they have had residents complain of cold food. Staff member M, who routinely worked the day shift, said the residents complained about cold food. Staff member M said getting the food reheated was a lot of trouble as the tray had to go back to the kitchen. Then the kitchen staff had to reheat it and take the food temperature, so residents didn't get burned. Staff member M said the food was only reheated for the residents who asked for their food to be warmed.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to maintain documentation of the COVID-19 vaccination status (received or refused) for one staff member (staff member M) of 2 sampled staff for COVID-19 vaccination status. Findings include: During an interview on 6/28/26 at 4:57 p.m. staff member M stated the facility offered COVID-19 vaccinations to employees. Staff member M stated she declined the initial COVID-19 vaccination series and did not recall if the facility had offered her the latest booster vaccination. Staff member M stated she did not remember if she signed a declination form for additional booster vaccinations the facility offered. During an interview on 6/29/26 at 7:34 a.m., staff member A stated the facility had a health fair in February or March of 2026 in which COVID-19 vaccinations were offered to all employees. Staff member A stated the facility could not find documentation showing which employees had received or refused the COVID-19 vaccination. A written request was submitted to the facility for staff member M's COVID-19 consent or refusal documentation on 6/28/26 at 1:55 p.m.; no documentation was received from the facility by the end of the survey on 6/29/26. Review of the facility's policy titled Prevention and Management of COVID-19 in Long Term Care, revised 9/6/23, showed: . DOCUMENTING COVID-19 VACCINE: 1. The center will maintain documentation for all residents and staff on COVID-19 vaccination and recommended boosters. 2. For staff, the information will be documented thru the [Facility name] Consent or Declination maintained in their employee health file. 4. The information to be documented includes: a) The staff, resident, or representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine. b) Whether the staff, resident, or representative consented to the vaccine. i) If yes: (1) Which vaccine was administered (2) Which dose was administered (3) Date of vaccination ii) If no, reason for refusal: (1) Contraindication (2) Refusal. [sic].		

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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. Based on interview and record review, the facility failed to notify residents and the residents' representatives in writing, of the reason for the transfer and the required bed hold information for 3 (#s 3, 6, and 56) of 20 sampled and supplemental residents. Findings include:1. Review of resident #56's nursing progress note, dated 5/27/26, showed the resident was transported to the hospital. During an interview on 6/29/26 at 10:20 a.m., staff member B said the nurses completed the initial transfer forms. Staff member B said she was unaware if the discharge or bed hold forms were completed for resident #56. Review of resident #56's electronic medical record failed to contain, and the facility did not produce, a Montana Notice of Bed Hold Policy or the Resident Notice of Transfer or Discharge form. 2. Review of resident #3's Resident Notice of Transfer or Discharge form, dated 3/24/26, showed a verbal acknowledgement was provided to resident #3's guardian on the transfer. The form failed to show which staff member received the verbal acknowledgement and which staff member provided a copy of the notice to the guardian. The Montana Notice of Bed Hold Policy dated 3/24/26 did not have the signature of the facility representative obtaining the verbal consent. Review of resident #3's Resident Notice of Transfer or Discharge form, dated 2/6/26, was missing the name of the staff member who notified the representative regarding discharge. The form showed verbal in the section that was identified as the person receiving a copy of the transfer notice. The form titled Montana Notice of Bed Hold Policy, dated 2/6/26, did not have a resident identified to show which resident was being transferred. The form also did not show the name of the responsible party who had been given the notice. 3. During an interview on 6/29/26 at 1:00 p.m., staff member I stated the nurse was responsible for completing a resident's transfer and bed hold form prior to a resident leaving the facility. Staff member I stated the forms were located at the nurse's station in a white binder. Staff member I stated that a transfer and bed hold form should have been completed for resident #6's transfer on 3/29/26 to an acute care hospital. Review of resident #6's electronic medical record showed that on 3/29/26, the resident was transferred via emergency medical services to an acute hospital due to a productive cough and difficulty breathing. The resident's electronic medical record failed to show that a transfer and bed hold notice had been provided to the resident or a family member at the time the resident was transferred to the acute care hospital. On 6/28/26, a request was made for a copy of resident #6's Notice of Transfer and Bed Hold for the 3/29/26 facility-initiated transfer. No documentation or records were received from the facility by the end of the survey. Review of the facility's policy titled Transfer and Discharge, updated May 2025, showed: (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	POLICY: . 5. When the transfer or discharge is initiated, the resident receives written notice using the Resident Notice of Transfer or Discharge which includes the following items: a. Date notice is given. b. Effective date of the transfer/discharge. c. Reason for the transfer/discharge. d. Where the resident is to be moved. e. Contact information for the State Long-Term Care Ombudsman. Review of the facility's policy titled, Bed Hold, updated May 2025, showed: Policy Statement: The resident and/or resident representative is informed of the Bed Hold Policy in writing upon admission, transfer, or leave of absence (LOA). If unable to provide at the time of transfer or leave of absence, the policy is provided within 24 hours.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to complete a baseline care plan which provided instructions needed to provide personalized resident-centered care for 1 (#28) of 20 sampled and supplemental residents. The failure to have a baseline care plan placed the resident at risk of not being provided care to meet their basic needs. Findings include: Review of resident #28's electronic medical record showed an admission date of 6/12/26, and the baseline care plan should have been completed within 48 hours of the resident's admission but was not. A review of Resident #28 medical diagnoses showed the resident was admitted with diagnoses of chronic pain and lumbar region spinal stenosis. The resident also had prior falls. Due to these, a baseline care plan would be important to ensure the resident's pain needs and fall prevention interventions were in place in a timely. Review of resident #28's admission MDS, with an assessment reference date of 6/16/26, showed the resident had frequent severe pain and was receiving nonpharmacological interventions for pain management. Resident #28's pain frequently limited her ability to perform day-to-day activities. The MDS showed resident #28 had falls in the last month and had falls two to six months ago. A review of resident #28's care plan showed the resident's risk for falls, assistance or needs for ambulating, bed mobility, and self-bathing performance, but resident #28 did not have a care plan in place directing the staff on how to assist the resident until 6/15/26. The care plan did not identify triggers for pain or interventions to help manage the pain until 6/15/26. The nonpharmacological interventions for pain management had not been added to the care plan. During an interview on 6/29/26 at 9:31 a.m., staff member D stated the care plans were triggered by the nurse evaluations, which are completed on admission. Staff member D stated the evaluations are reviewed for completion and signature during the daily clinical meeting. The baseline care plans were started and would be dated when the evaluations were done, signed, and locked. Staff member D said that if the resident had known falls before admission, the way the corporate care plans were set up, those falls would not trigger a care plan.		