STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275091	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Home	1225 Perry LN Glasgow, MT 59230

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48261 Based on observations, interviews, and record review, the facility failed to monitor a cognitively impaired resident with a known history of elopement attempts, which resulted in the resident leaving the building unsupervised, putting the resident at risk for serious injury or death for 1 (#2) of 2 sampled residents for elopements. Findings include: Review of a Facility Reported Incident, sent to the State Survey Agency for resident #2, dated 4/14/24, showed, Call received from another resident who was outside of facility reporting resident [#2] was outside at [School Name] playground alone. [Staff member name] received a call from [staff member] that she found resident at [School Name] and she would not get in her vehicle to bring her back to facility. [Staff member] arrived at [School Name] and [resident #2] was returned to facility by [staff member] in private vehicle. During an observation on 6/3/24 at 2:45 p.m., resident #2 was asleep in her room, one door away from the exit door. During an interview on 6/3/24 at 3:10 p.m., staff member D stated all residents at risk for elopement reside in the secure unit, and not out in non-secured unit. Staff member D stated resident #2 could go outside by herself to walk, and staff call the transit bus for her to go to appointments. During an interview on 6/3/24 at 3:16 p.m., staff member E stated resident #2 eloped on 4/14/24 at 7:00 p.m. to [School Name], which was 0.4 miles away, and it took about 8 minutes to walk to, per her internet search. Staff member E stated resident #2 had told staff she was going to walk around the building. During an observation and interview on 6/4/24 at 7:50 a.m., staff member E stated resident #1 was the only elopement risk out on the non-secured unit. Staff member E stated the facility had an elopement book, but she could not locate the book at the time of the interview. Staff member E asked staff member D where to locate the book and staff member D stated the book was supposed to be on the desk. Staff members D and E located the book in a wall file behind stacks of papers. Staff member E reviewed the book and stated two residents were at risk of elopement, including residents #1 and #2. During an interview on 6/4/24 at 7:55 a.m., staff member F stated she was not aware resident #2 was on the elopement risk list. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 8:02 a.m., staff member H stated she was not aware residents #1 or #2 were on the elopement risk list. During an interview on 6/4/24 at 8:04 a.m., staff member G stated she was not aware residents #1 or #2 were on the elopement risk list. During an interview on 6/4/24 at 8:06 a.m., staff member C stated, [Resident #2] forgets easily, and the family told us that at admit, and it was obvious from day one too. During an observation and interview on 6/4/24 at 9:06 a.m., resident #2 was walking very fast down the hall, using a four wheeled walker. Staff member G told resident #2 to slow down. Staff member G stated resident #2 was a fast walker and staff had to remind her to slow down so she would not fall. Resident #2 declined to speak with the surveyor. Staff member G stated staff could usually talk to her and she would respond, but most of her speech is unintelligible. During an interview on 6/4/24 at 10:35 a.m., staff member A stated the facility was not doing a great job ensuring the elopement risk residents and their interventions were communicated to the staff on the floor. Staff member A stated the facility was planning to add an elopement huddle to the morning huddle meetings, but had not done so yet. During an interview on 6/4/24 at 1:30 p.m., staff member B stated she was not aware resident #2 was a elopement risk until 6/3/24. Staff member B was new to her position and felt that resident #2's elopement was likely a result of the change in weather. Staff member B stated when the weather is warmer, several residents can leave on their own. Staff member B stated she felt resident #2 saw other residents leaving the building and thought she could too. Staff member B stated she wished the facility had an elopement bracelet system but could not explain why staff did not know resident #2 had left the facility and had made her way to the park before another resident noticed her at the park. Review of resident #2's Fact sheet, with a print date of 6/3/24, showed the following mental health diagnoses: - Fetal alcohol syndrome - Schizophrenia - Moderate intellectual disability - Depression - Developmental disorder of scholastic skills Review of resident #2's MDS, with an assessment date of 4/24/24, showed resident #2 had a BIMS of 12. Review of resident #2 PASRR II, dated 8/7/23, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- . Behavioral and Functional Impacts relating to Mental Health Past 3/6 Months: Going outside without supervision, walking and wandering away. Patient is easily confused and needs frequent redirection and continuous supervision to keep her safe. Patient has lack of awareness and insight into what her needs are and is unable to make rational or reasonable judgements concerns regarding her well-being. - . The uncle reports that the biggest concern for the patient is her wandering away unsupervised. When this has occurred, she ended up in very dangerous and unsafe situations due to her lack of awareness and lack of comprehension. Review of resident #2's Elopement Care Plan, with a problem start date of 7/14/23, showed resident #2 was . at risk for elopement as evidenced by a history of wandering outside at nighttime. The Approach (interventions) included: - .Provide me with continuing education on importance of not leaving facility as due to my cognitive impairment I am forgetful. (start date 7/14/23) - Use verbal cues and gentle touch to redirect my exit-seeking behaviors. (start date 7/14/23) - I have my information and photo in a binder at each nurse's station so staff is aware that I am at risk for elopement. (start date 7/14/23) - Ensure I do not accidentally follow visitors out of the building (start date 7/14/23) - I enjoy dogs and cats very much and I will attempt to follow them out of the building as I am forgetful. Please remind me not to follow visitors and pets out of the building. (start date 7/18/23) - If I am overheard talking about leaving facility to go do something, please provide me reminder that I am unable to go by myself. (start date 4/15/24) . Staff members D, E, F, and G were unaware of resident #2's risk of elopement, and were unaware of the interventions to prevent elopement for resident #2. Review of resident #2's progress note, dated 4/14/24, showed resident #2 had .asked for someone to take her but no one wouldn't (would). [sic]