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	01/29/2026

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

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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 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 ensure necessary and beneficial interventions were identified and implemented for the supervision of a resident (#1) who displayed various behaviors and this resident wandered into other residents' rooms which increased her risk of harm if others acted out on her. Resident (#1) had interactions with male residents, which were sexual in nature, and on one occasion, she was found in the male's room when the encounter was occurring. The facility implemented behavioral and medication interventions to help intervene in her behaviors but failed to implement a monitoring and supervision program that would meet resident #1's safety needs as related to her wandering and the sexual encounters she experienced. Staff documented she continued to have her baseline behaviors, and her behaviors changed in some areas, such as refusing medications and or care, but these were not clearly linked to the interactions she had with the two male residents. Resident #1 later transferred to the hospital and had not returned. Findings include:During an interview on 1/28/26 at 3:00 p.m., staff member E stated that abuse training for staff was assigned annually. Staff member E stated that if allegations of abuse were received, the charge nurse was to be notified immediately, and if the allegations happened at night, the DON was to be notified. Staff member E stated she also received Dementia training, but could not remember the date.During an interview on 1/28/29 at 3:10 p.m., staff member D stated she heard resident #1 yelling one day, saying, help me. Staff member D stated resident #1 was found lying crossways on the bed, and a male resident was lying on top of resident #1. The male resident had no clothing on the bottom half of his body. Resident #1 was completely dressed. Staff member D separated the residents and redirected the male back to his room. Staff member D stated resident #1's behaviors had worsened following the incident. Staff member D stated that resident #1 liked to dance, and staff would take her outside when the weather permitted. During an interview on 1/28/26 at 3:05 p.m., staff member E stated resident #1 had a history of trauma but could not remember what the trauma was related to. Staff member E stated that staff tried several interventions to attempt to calm the resident when she was upset, such as giving her snacks and showers. The physician made medication changes for her behaviors, but the resident was still experiencing an increase in her behaviors over time. Staff member E stated that other staff who worked off the unit would come and try to help calm the resident when resident #1 was displaying behaviors, such as running around the unit, aggression, or yelling at staff.During an interview on 1/28/26 at 3:18 p.m., staff member F stated that if a resident-to-resident altercation was observed, he would separate the residents from each other (to protect them) and report the incident to the nurse. Staff member F stated that staff were told resident #1 had been abused previously (before coming to the facility). Staff member F stated that resident #1 did not like black hair or black clothing. During an interview on 1/28/26 at 5:02 p.m., staff member A stated that when resident #1 was in the hospital, she had auditory and visual hallucinations. Staff member A stated the resident would say, He's coming, for her. Staff member A stated the (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	resident blamed everything that went wrong on her sister. Staff member A stated that resident #1's behavior was verbal and physical toward staff. Staff member A stated the resident would go in and out of other residents' rooms. Staff member A stated that staff were documenting resident #1's behaviors, and there was an increase in physical behaviors towards the staff. The resident was also refusing medications and care and was slamming doors. Staff member A stated the resident was very disruptive to the care environment. Staff member A stated that resident #1 was taking her clothes off and attempting to follow male residents into their rooms. During an interview on 1/29/26 at 9:02 a.m., staff member I stated they were monitoring resident #1's behaviors after the event where the male was found in her room lying on top of her, where she had her clothes on, but he had his bottoms off. The staff wanted to see if resident #1 had an increase in behaviors. Staff member I stated that abuse training was completed at least annually. Staff member I stated there had been behavioral and dementia training for staff within the last year. Staff member I stated that if an altercation occurred, she would separate the residents to ensure their safety. Staff member I stated she would notify the physician, family, the resident representative, charge nurse, DON, and Social Services about the event. Staff member I stated the resident's interventions for behaviors depended on what was in the care plan. Staff member I stated, We used to give resident #1 back rubs, provide music, food, and drinks when she displayed behaviors. Staff member I stated there was an incident in which the resident had been locked in her room, which happened before she came to the facility.During an interview on 1/29/26 at 9:48 a.m., staff member B stated that when there was an altercation between two residents, staff would need to intervene. The incident would need to be investigated and get both sides to determine what triggered the incident. Staff member B stated that staff members A and B do the reportable incidents. Staff member B stated that the staff tried multiple interventions with resident #1, including aroma therapy, redirection, food, fluids, and quiet time. Staff member B stated the interventions would work sometimes. Staff member B stated the resident was living with a family member, and the family member would get frustrated and lock her in her room. Staff member B stated it was unclear what other incidents contributed to her trauma before she came to the facility. Staff member B stated that the staff was trained in abuse and behavioral health yearly.Review of resident #1's Nursing Progress Notes, dated 7/1/25 - 12/23/26, showed the following:12/3/25 - A male resident was found in resident #1's room with his hands down the front of resident #1's pants. Resident #1 was saying, I don't like you. The male resident was redirected to his room. The provider reviewed resident #1's medications and made changes. There was documentation that showed the staff were to monitor resident #1 for increasing behaviors, but the documentation did not show how long this would occur or the level of monitoring that was to occur and how the staff were to keep resident #1 safe. 12/4/25 - The nurse documented the resident keeps shirt tucked in walking around with hands in pants, and later in the day it was also documented on that day that she had no changes due to the incident with the male resident on 12/3/25. Documentation showed that between 12/4/25 and 12/22/25 the resident continued to have ongoing behaviors, and on many days, was documented to be at her baseline (for behaviors). 12/22/25 - Resident #1 was found in a male resident's room, lying on the bed. Resident #1 was fully clothed. The male resident had no pants on, and he was lying on top of resident #1. The male was making thrusting downward movements with his body. Staff heard resident #1 say, Get off, repeatedly. Staff separated the residents, took resident #1 back to her room, and staff were to monitor the resident more closely. There was no documentation showing how long the monitoring was to occur or to what degree she would be monitored for the safety of herself or others. 12/23/25 - Resident #1 was very emotional, angry, and upset. The resident was going in and out of other resident rooms, trying to take (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their belongings. The resident had extreme agitation and displays of behavior while menstruating. The staff implemented interventions for her behaviors with little to no improvement during her stay. On this day, the resident was given Haldol 5 mg intramuscular as a one-time dose. The medication took 30 minutes to be effective. Review of resident #1's monthly behavior review, for the various behaviors she displayed, dated 7/1/25 - 1/9/26, showed:7/2025 - Resident #1 displayed: wandering, pacing, physical action towards staff, wandering into other residents' rooms, yelling, she was resistant to care, and was displaying paranoia.8/2025 - Resident #1 displayed: wandering the halls, going into other resident rooms, yelling, pushing away from staff, refusing medication, she was resistant to care, and displayed physical and verbal aggression towards staff.9/2025 - Resident #1 displayed: wandering halls, going into other resident rooms, refusing staff redirection, crying, verbal hallucinations, mumbling, refusing to use briefs, pacing, ambulating quickly, and jogging on the unit. 10/2025 - Resident #1 displayed: crying, wandering, yelling, pacing, cursing, and agitation. 11/2025 - Resident #1 displayed: yelling, aggression, cursing, wandering into other residents' rooms, was tearful, refusing care, and pacing. 12/3/25 - The first incident with the male resident occurred where resident #1 was found in her room with the male. 12/22/25 - The second incident with another male resident occurred. Resident #1 was found in a male resident's room. There was no documentation in the behavior review documentation for what occurred in the male resident's room (it was included in the nursing notes). 12/22/25 - Resident #1 was wandering, pacing, she had her hands in her pants, was verbally abusive to staff, screaming, running, and agitated. The resident tried to pull her pants down in the common area of the unit. Having her hands in her pants and removing her clothing were not documented prior. After 12/22/25, resident #1 continued to refuse her meals and medications, she would yell and curse, displayed aggression toward staff and or other residents. She was slamming and banging on doors and chairs, windows or walls. Resident #1 knocked the table/chairs over and stated that people were trying to kill her or be mean to her. The resident continued to experience challenging behaviors, which put herself and others at risk of harm, and the facility did not attempt to identify if any of her behaviors displayed were stemming from the interactions with the male residents, which were sexual in nature. Review of resident #1's Behavior Review notes, dated 7/1/25 - 1/9/26, showed resident #1 had triggers including incontinence, reportables (reportable events), shingles-exacerbated behaviors possible, dental increased behaviors-pain? Did not like clothes picked out some days-increased behaviors, and phone calls with family. Interventions included room change on 2/4/25, snacks, one-on-one, walking with staff, back rubs, conversations, aroma therapy, warm towels, new face (different staff), pain management, toileting, hair brushing, lavender, and offered different comforters. Under thoughts, it showed the resident's medication was managed by the physician and a psychiatrist's involvement with her care. The notes showed, Meeting sooner about behaviors to implement psychiatrist? Review of resident #1's care plan showed:9/23/24-Cognitive Loss/Dementia. Interventions included If I lose attention during the conversation please attempt to regain my attention and repeat what was said. There was a start date of 9/26/24, and the care plan showed, provide me with consistent caregivers and routine when able. All other interventions were implemented 9/26/24.10/11/24-Psychosocial Well-Being. Interventions included, I have a history of trauma that affects me negatively. All interventions had a start date of 10/11/24, including for staff to encourage the resident to express her feelings, concerns, and thoughts in a safe place. Staff were to assist resident #1 with recovery and avoid (trauma) triggers. The care plan showed, My history of trauma includes car accidents, fires, heart attacks, death in my family, and the murder of my aunt. There were no triggers related to prior sexual abuse identified on the plan. 9/10/24-Behavioral Symptoms. Interventions started on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/28/25, which included attempt to assess me (resident #1) for pain when I am experiencing agitated behaviors, attempt to offer different staff members, during my menstruation I am known to have worsening behaviors, if I am observed to be agitated, attempt to provide me with aroma therapy, and offer me a warm towel to help soothe me if I am observed to be agitated.The resident's care plan failed to show attempts to identify new contributing factors and interventions implemented in an attempt to prevent behaviors, to protect her due to her behaviors, or what level of monitoring and oversight the resident needed to remain safe. Review of the Behavior Review document, dated 7/1/25 - 1/9/26, showed the following medication changes:Scheduled daily:7/15/25; Abilify, an antipsychotic, 15 mg two times daily6/5/25 - 7/15/25; Abilify 10 mg two times daily9/17/24; fluoxetine, an antidepressant, 20 mg every morning6/4/25 - 11/7/25; Seroquel, an antipsychotic, 50 mg two times daily12/9/25 - 12/30/25; Seroquel 100 mg three times daily12/30/25 - 1/2/26; Seroquel 200 mg three times daily1/2/26 - 1/4/26; Seroquel 200 mg three times daily1/4/26 - 1/6/26; Seroquel 200 mg three times dail7/3/25 - 7/9/25; Haloperidol, an antipsychotic, 5 mg every nightResident #1's Seroquel was changed multiple times with little to no effect, as evidenced by her behavior documentation.Resident #1 had Seroquel (antipsychotic), Haloperidol (antipsychotic) and Ativan (antianxiety), as needed.Resident #1 was transferred to the hospital on 1/6/26 and did not return to the facility as of the survey.

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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 ensure an incident was reported within 24 hours of the date of the incident for 1 (#8) of 10 sampled residents. Findings include:During an interview on 1/29/26 at 9:48 a.m., staff members B and C stated the time frame for reporting incidents was 24 hours. Staff member B stated that as soon as we hear about a reportable, we start the investigation. Staff member B stated that the staff abuse training is done yearly. Staff member B stated there are in-services on abuse and reporting timelines throughout the year.During an interview on 1/29/26 at 10:00 a.m., staff member A stated the administrator, DON, and Social Services are responsible for obtaining statements from staff and residents. Staff member A stated the time frames for reporting to the State Survey Agency were two hours for serious bodily injury, or 24 hours if there is no serious bodily injury. Staff member A stated the findings are to be reported to the State Survey Agency within five days. Review of an incident of abuse submitted to the State Survey Agency, on 8/18/25, was more than 24 hours after the date of the incident. The date of the incident was on 8/16/25. The incident involved a resident-to-resident altercation between residents #8 and #10.Review of the facility policy, titled Mandatory Reporting for Montana Nursing Facilities, showed:7 .Resident to Resident Abuse was not to exceed 24 hours from the discovery of the incident .There is a 2-hour reporting requirement for crimes resulting in serious bodily injury .Investigation results must be sent to the state agency within 5 working days of the receipt of the report of abuse .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to designate a full time DON. Findings include:During an interview on 1/29/26 at 9:48 a.m., staff members B and C stated the facility was without a DON for a little over a month. Staff member C stated the DON tasks were divided between the IDT.Review of an email from staff member A showed an advertisement for the DON position with a posting date of 9/8/25. The email goes on to show the IDT took over the DON tasks.During an interview on 1/29/26 at 10:00 a.m., staff member A stated the new DON started on 10/16/25.Review of an email sent by staff member A, dated 9/8/25 at 2:34 a.m., showed the previous DON no longer worked at the facility. There was no documentation available to show the prior DON's duties were specifically reassigned to an RN (or multiple RNs), until a new DON was recruited. Review of an email sent by staff member A, dated 10/16/25 at 3:26 p.m., showed staff member B started as DON on 10/16/25. The facility was without a DON for 37 days.