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	06/17/2026

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observations, interviews, and record review, the facility failed to provide meaningful activities for residents for 2 (#s 43 and 44) of 10 memory care residents. This deficient practice increased the risk of the residents becoming bored or escalating their behavior. Findings include: 1. During an observation on 6/16/26 at 2:45 p.m., staff members G and L were sitting at the nurses' station in the memory unit. Resident #43 was sitting in the dining room at a table by himself. Resident #43 was not involved in any activity. Resident #43 got up from his chair and went to his room and came back out a moment later, wandering in the hallway, and then to the common room where he sat in the recliner watching television. Resident #43 got back up a few minutes later and wandered back to his room. There was not an activity occurring at the time. 2. During an observation and interview on 6/16/26 at 3:10 p.m., resident #44 slept on the couch in the common area. Staff member G stated that resident #44 preferred to sleep on the couch throughout the day and night. Staff member G stated that resident #44 had a fear of sleeping in her room. After this surveyor questioned why the resident slept all day on the couch, as it was noted there was no activities occurring at the time, staff member G got the resident up by offering the resident a Dilly Bar and taking her out for some fresh air outside in the common area. During an interview on 6/16/26 at 3:13 p.m., staff member G stated the CNAs did not have regular activities in the memory unit. Staff member G stated, We just let things happen naturally. They (the facility) have a calendar (for activities), but we don't really do those things. Staff member G stated there was not even a copy of the activity calendar back in the memory unit. Staff member G then turned the television to a music concert. Staff member L entered the interview and stated the television had been on the same show for two days straight. Staff member L stated they did not understand why the show had not been changed. During an interview on 6/17/26 at 8:01 a.m., staff member B stated she had seen a few activities occur in the memory unit, including towel folding, and tactile boards were provided for the residents to use. Staff member B stated there had been discussion around needing more activities in the memory unit, but she had not had time to address the concerns yet. During an interview on 6/17/26 at 1:18 p.m., NF3 stated resident #43 needed more activities. NF3 stated the facility did not provide quality of life for the residents residing in the memory unit, and CNAs sit at the nurses' station, ignoring the residents. NF3 stated the residents needed more time outside in the nice weather, more music activities, and more ambulation/exercise. NF3 stated she believed resident #43 was restless, and this led to more of his behaviors. NF3 stated she voiced these concerns with staff member K on multiple occasions and again during the care conference. During an interview on 6/17/26 at 2:25 p.m., staff member E stated the activities provided to the (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	memory unit residents included the Buzz newspaper being passed out, towel folding, dietary treats being served, church services if wanted, tactile boards, and coloring supplies being provided to staff to use, and one resident had her nails painted. Staff member E, who provided oversight for activities, stated there was no specific calendar developed to meet the needs of the memory unit population. Staff member E stated she thought the CNAs on the unit were doing activities with the residents in the memory unit. During an interview on 6/17/26 at 4:23 p.m., staff member C stated she had voiced concerns to management about the resident's behaviors and lack of activities in the memory unit. Staff member C stated she had noticed on many occasions that residents were bored, and no activities were occurring in the memory unit. Staff member C stated she believed the lack of activities in the memory unit played a role in the number of behavioral incidents occurring in the memory unit. 3. During an interview on 6/16/26 at 10:50 a.m., NF1 stated that often staff on the memory care unit were just kind of sitting there with no interaction between staff and residents. NF1 stated the orientation board, which should detail the day, weather, upcoming holidays, etc. was often not updated, and activities staff did not go around and gather residents who may not be able to bring themselves to the scheduled activity at the time, so they would not participate in an activity. During an interview on 6/17/26 at 10:21 a.m., NF2 stated they hadn't seen much going on for entertainment in the memory care unit. NF2 stated, Basically, all them gals do is watch TV. During an interview on 6/17/26 at 2:26 p.m., staff member E stated that if a resident had participated in an activity, activity documentation would be found in the medical record. Staff member E stated they did not think the activities staff were documenting what they were doing for the resident(s). Review of the facility's policy, Activities, dated 11/2020, showed: - . 5. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review, the facility failed to ensure the IDT team verified a resident who was self-administering medication was determined to be clinically appropriate to self-administer medications, and medications were left for the resident to take independently, without supervision, for 1 (#4) of 26 sampled medication administrations. Findings include:During an observation on 6/17/26 at 11:27 a.m., staff member K prepared two acetaminophen 500 mg tablets for resident #4, placing them in a pill cup and taking them to the resident's room. Staff member K placed the medication cup on the bedside table and left the room without observing the administration of resident #4 taking the medications. During an interview on 6/17/26 at 11:28 a.m., staff member K stated resident #4 did not appear to have a self-administration of medication assessment. Staff member K stated she did not think about it before she left the medication without observing him taking the pills. Staff member K stated she knew she should stay with residents when administering medications and usually did. Review of resident #4's EHR on 6/17/26 did not reflect a self-administration assessment, self-administration noted in the care plan, or an order for self-administration of medications. Review of the facility's policy, Resident Self-Administration of Medication, dated 11/16/23, showed:- . 4. If the resident requests to be able to administer medications independently, a nursing team member will complete the Self-Administration of Medication Observation in [EHR software].- 5. Upon notification of the use of bedside medication by the resident, the care plan will be updated to reflect the resident's wishes, and the MAR will be updated to reflect the resident's self-administration capability.

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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 interviews and record reviews, the facility failed to ensure two vulnerable residents were not subjected to abuse, neglect, or psychosocial harm, when a staff member P physically and mentally abused resident #47 when the resident was resisting care, and when the same staff member left resident #43 unattended at an out of town appointment, neglecting her safety and supervision needs, for 2 (#s 43 and 47) out of 18 sampled and supplemental residents. Using the reasonable person perspective, both vulnerable residents may have ongoing psychosocial harm, fear, or behavior related to the abuse and neglect events involving staff member P. Findings include: 1. Review of a written warning, dated 3/5/26, showed staff member P left a cognitively impaired resident alone at an out-of-town appointment while the resident was in his care, neglecting the resident's safety. The resident was left in the corner of a corridor for at least an hour, with the wheelchair locked, and no one was there to assist or help the resident. When the resident was found by witnesses, she was observed to be choking on her supplement. The facility documented this incident as abuse, neglect, and use of restraint(s). Review of the facility's incident report dated 3/12/26 showed the facility determined resident #47 was dropped off at an out-of-town dental office by staff member P and was left unattended for over an hour due to the dental office being closed for lunch. Staff member P neglected to ensure the resident has supervision at the time. Resident #47 was found by nearby concerned individuals to be in distress and in need of assistance. When found, resident #47 appeared to be coughing/choking and had spilled a supplemental drink on herself. The concerned individuals stayed with resident #47 until the dental office staff returned from lunch. This incident was reported to the facility by the concerned individuals who found resident #47. Upon returning to the facility, staff member P received a disciplinary write-up, was immediately suspended from work without pay, and would be required to complete education on neglect, restraints, abuse, and safe transportation of residents before being considered to return to work. Review of resident #47's medical record showed a BIMS of 10; moderately impaired cognition. Resident #47 had diagnoses of traumatic brain injury, quadriplegia, and major neurocognitive disorder. During an interview on 6/17/26 at 3:15 p.m., staff member Q stated they drove residents to and from the facility for various appointments. Staff member Q stated, I am with them the whole time unless the resident doesn't want me in the room. Staff member Q stated they were told to do this by other staff. Review of education provided to staff member P, dated 3/16/26, showed staff member P was educated on not leaving residents unattended at medical appointments, clinics, or other off-site locations unless prior arrangements had been made and approved by nursing, leadership, or administration. Review of the facility's resident transportation and scheduling policy, dated 3/21/23, failed to address leaving cognitively impaired residents unattended. 2. Review of a facility investigation report, dated 5/26/26, showed: - . The allegation of staff-to-resident abuse was verified through witness statements and the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's internal investigation. Witness accounts confirmed that the staff member used inappropriate physical interventions while attempting to assist the resident, including grabbing the resident by the hair, arm, and beard. [sic] Review of the facility's witness statement from [staff member O], dated 5/27/26, showed: - Staff member O observed staff member P holding resident #43's right forearm and holding his hair on top of his head. Staff member P pushed resident #43 against a wall, and resident #43 sat onto the bedside table against the wall. Staff member O stated that staff member P then let go of resident #43's hair on his head and grabbed his beard, pulling his head forward. Staff member O stated she then yelled at staff member P, and he released resident #43's hair and walked him to the bathroom with the assistance of staff member G, without resident #43 resisting, hitting, kicking, or yelling. Although staff member P had been educated on resident abuse in March 2026, related to leaving the resident unattended at an appointment, staff member P continued to disregard the safety and care needs of the residents. Review of the facility's witness statement from [staff member G], dated 5/27/26, showed: - Staff member G stated she found resident #43's toilet was covered in feces and requested staff member P's assistance in cleaning up resident #43. Staff member G stated that resident #43 was being aggressive toward staff. Staff member G stated she was in the bathroom when she heard resident #43 yell, and she looked back to find staff member P holding resident #43 by the top of his head and his chin. Staff member G stated she heard staff member O yell, [Staff Member P's name] that's enough! and staff member P released resident #43. Staff member G stated she then coaxed resident #43 into the bathroom, and he continued to resist, but she was able to get him cleaned up. During an interview on 6/16/26 at 8:23 a.m., staff members G and L both stated resident #43 had a history of hitting staff and being aggressive during ADL care. Staff member G stated that when resident #43 became aggressive, they would step away, unless he was really dirty, then the staff would use 2-person assistance approach, with one redirecting his hands while the other staff member hurried to clean him up. Staff member G stated, It just has to be done, while staff member L stated, Yes, it (cleaning him up) needs to get done. During an interview on 6/17/26 at 1:18 p.m., NF3 stated she was very upset and broken hearted by the staff abuse incident involving resident #43. NF3 stated she did not feel the facility handled the situation appropriately, specifically not having resident #43 assessed in the emergency room immediately after the incident occurred. NF3 stated she was aware that resident #43 could be difficult when he was forced to do things he did not want to do. NF3 stated she felt the staff involved should not have forced him to clean up and should have stepped back and let him calm down. NF3 stated that resident #43 would get angry and defensive when staff forced him or yelled at him in a rushed voice. NF3 stated she had shared this concern with staff member K on multiple occasions. NF3 stated she did not understand why they were forcing him to toilet and not reapproach him later. NF3 stated staff member K wanted to give him a shot (medication) to sedate him so they could change him and get him cleaned up after the incident, and she again reminded staff member K she did not want resident #43 sedated and to wait for him to calm down and reapproach him. NF3 stated that when she arrived at the facility on 5/28/26, resident #43 was lying in his bed, fiddling with his hands, acting as if he was not allowed to get up while staring at the bedroom door. NF3 stated she chose to take NF3 to the emergency room herself to be assessed for any injuries related to the abuse incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of All staff meeting, dated 1/2026, showed staff members G, L, and O had attended, Resident Abuse Prevention and Reporting. Review of the facility Education labeled, Resident Abuse Prevention and Reporting, not dated, showed: -Page 7, slide 1: . Physical Abuse: . Controlling behavior through corporal punishment (using physical force as a means of discipline). Review of staff member P's employee file showed:

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews the facility failed to ensure boxes of resident food and drinks were stored off the floor in the kitchen area, and the improperly stored foods may be exposed to dust, pests, moisture, and other environmental hazards, affecting any resident eating food prepared or served by the kitchen. Findings include:During an observation on 6/16/26 at 7:42 a.m., one box of supplemental drinks was found on the floor upon entering the kitchen.During an observation on 6/16/26 at 7:46 a.m., two cases of Gatorade, one case of green beans, and one case of supplemental drink were on the dry storage floor.During an observation on 6/16/26 at 2:30 p.m., a box of supplemental drinks were found on the floor, propping open the kitchen door.During an interview on 6/17/26 at 8:35 a.m., staff member M stated the food delivery truck came late the previous day, she was aware of the food not being put away, and it was on the floor. Staff member M stated she was also aware of the supplemental drink being used to prop open the kitchen door. Staff member M stated that had been the practice since their door stopper went missing, they would grab something nearby to prop the door open. Staff member M, who provided oversight for the kitchen policies and procedures, stated she knew they should not store boxes of food on the floor.