STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275107	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Fork Valley Nursing Home	10 Kruger Rd Plains, MT 59859

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview, and record review, the facility failed to document a thorough investigation of an allegation of sexual abuse for 1 (#8) of 14 sampled residents. This had the potential to cause the facility to miss key parts of the investigation. Findings include: During an observation and interview on 4/7/26 at 8:36 a.m., resident #8 stopped two surveyors in the hall and stated, I just want to tell you guys about how wonderful this place is. During this conversation resident #8 stated she did have an incident at one point, and the facility handled it professionally and discretely. Resident #8's demeanor was happy and joyful. Resident #8 was joking and smiling during this whole conversation.During an observation and interview on 4/7/26 at 2:45 p.m., resident #8 stated the incident she was referring to earlier was an incident where she felt she was touched inappropriately by a male staff member. Resident #8 stated, It was total innocence on his part. He did apologize and he felt so bad he quit working here. Resident #8 described the incident and explained the staff member was assisting another staff member with powder application to private areas. Resident #8 stated she has had no other concerns, and the facility handled it appropriately. Resident #8 stated the staff treated her with respect and dignity through the whole process along with the officer that investigated the incident. Resident #8 stated she is no longer bothered by the situation. During this conversation the resident was smiling and appeared happy, she did not show signs of fear or sad emotion. During an interview on 4/8/26 at 8:02 a.m., staff member A stated, We have never had an allegation to this extent before and were unsure of how to go about the investigation. We followed our process and summarized it. We did not document all the conversations we had when interviewing other staff or residents. Since we could not determine the exact date of when the incident occurred, we did not do a physical assessment of the resident. We removed the staff member and reported it as soon as we were made aware of the concern. We provided the summary to APS and the police, and they conducted their own investigation. I guess we figured they were handling it. During an interview on 4/9/26 at 8:36 a.m., staff member B stated, Our process for incident investigations is to follow the investigation process. We go into Bounds and report it if it is reportable, then we conduct an investigation, and write up a summary of the investigation and the steps that were taken. Then we ensure it is care planned. For resident #8's incident, I reassigned skin checks to another nurse and removed the staff member. I did not realize I had to record all the conversations or details of each piece of the investigation. I just compiled it into a summary of what was done. Review of the facilities investigation file for an incident dated 1/29/26 failed to show what other residents were interviewed, all staff that were interviewed, the details found in those interviews, and the dates the interviews were conducted. The investigation file consisted of a brief summary of facility events, the APS report, a statement from the police department, and the bounds report. Review of a facility document titled Abuse, Neglect & Exploitation of Elderly and Disabled with an effective date of 1/2025, showed: .Purpose: The purpose of this policy is to promote and ensure the highest level of safety for our patients and residents by establishing a mechanism to monitor any complaint or incident of suspected physical or verbal abuse.Investigative Process:1. All alleged violations involving mistreatment, neglect, or abuse. shall be reported to the administration of the facility. (including to the State survey and certification agency).3. The facility will thoroughly investigate all alleged violations through (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	established procedures. In the event of any case of suspected abuse, the Patient or Resident will be removed from the care of the alleged abusive party until the case is fully investigated and resolved.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to refer a resident with a new diagnosis of bipolar disorder to the appropriate state-designated mental health authority (PASRR) for review for 1 (#6) of 14 sampled residents. This deficient practice had the potential to cause a delay or missed services for resident #6 to meet their highest practicable mental health status. Findings include: Review of resident #6's PASRR screening with a date of 6/26/23, showed: .Review outcome: Approved. Diagnosis: CEREBRAL INFARCT D/T EMBOLISM MID CEREBRAL ART, APHASIA, DYSPHAGIA, DEPRESSION UNSPECIFIED, CHRONIC OBSTRUCTIVE PULMONARY DISEASE UNS, ESSENTIAL PRIMARY HYPERTENSION, TYPE 2 DIABETES MELLITUS, OSTEOARTHRITIS UNSPECIFIED SITE. [sic]Review of resident #6's diagnoses list in his electronic medical record showed: .Description: Bipolar disorder, unspecified, Date: 6/26/23, Created Date: 8/29/23.Review of resident #6's Quarterly MDS, with an ARD of 1/5/26, showed: MDS 3.0 Section I - Active Diagnosis, I5900. Bipolar Disorder: Yes.During an interview on 4/8/26 at 12:13 p.m., staff member H stated her process for completing the PASRR was to gather information through the Epic system (electronic health records) and the H&P, and she will enter whatever diagnoses are on them. She stated she would especially add any mental health diagnosis other than dementia. Staff member H stated she had never had a PASRR screening denied or that needed a Level II. Staff member H stated that a new diagnosis of bipolar disorder should prompt a new PASRR referral to be completed. Staff member H stated that for resident #6 specifically, she had used the diagnosis taken from the resident's H&P, as he came from another facility. Staff member H stated, Bipolar should be reflected on the PASRR, and another PASRR should have been submitted for resident #6. Staff member H stated she had never had to resubmit a PASRR for any of the long-term care residents because their diagnoses rarely change. Staff member H stated, I think that one of his (resident #6's) diagnoses just got missed.The facility did not have a policy for completion of the PASRR or when to resubmit a PASRR referral.