STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275126	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation	1301 E Broadway Missoula, MT 59802

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 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 review, the facility failed to ensure a resident was free from misappropriation of resident funds by a staff member for 1 (#48) of 25 sampled residents. This deficient practice resulted in the loss of $500 plus travel expenses for resident #48. The facility identified the failure of a staff member accepting money from a resident and addressed and corrected the deficient practice before the survey, resulting in the findings of past non-compliance. Findings include:During an interview on 1/13/26 at 12:01 p.m., resident #48 stated he met staff member Q at the facility. Resident #48 stated he and staff member Q became friendly and at some point, in December of 2025, staff member Q offered to assist resident #48 with travel to [City] for medical appointments. Resident #48 stated that staff member Q agreed to be paid $1000 plus expenses. Resident #48 stated he purchased two first-class airline tickets and booked hotel rooms for the trip. Resident #48 stated he paid the staff member Q $500 up front and agreed to pay the remaining $500 after the trip. Resident #48 stated he paid staff member Q the $500 using his personal checking account, check #0101, and the check was cashed. Resident #48 stated, I thought he would just send me my money back. I had sucker written on my forehead. I want to get my money back; maybe it's time to get the sheriff back here. During an interview on 1/13/26 at 12:10 p.m., staff member A stated resident #48 declined to pursue charges against staff member Q during the initial police report, but she would immediately assist resident # 48 in calling the sheriff back to file charges against staff member Q and pursue reimbursement of all funds involved in travel plans previously made. Staff member A stated resident #48 had a BIMS of 15, cognitively intact, and was able to make his own decisions. Staff member A stated staff member Q was immediately removed from the schedule, and the police, spouse, his primary employer, Adult Protective Services, his physician, and the State Survey Agency were notified. Staff member A stated an investigation of possible misappropriation of funds from other residents found no other residents were affected. Staff member A stated the facility did re-education with all staff on 1/8/26, and a QAPI action plan was put into place. Review of text messages on resident #48's phone, dated 12/11/25 - 1/2/26, reflected staff member Q and resident #48 discussing payment for his services, the hotel, food, airline tickets, and a rental car. On 12/20/25, staff member Q requested payment for services in advance of the trip due to financial difficulties. On 12/21/25, resident #48 agreed to pay half of the $1000 for staff member Q's services, which was travel assistance to and from the travel destination. Review of a personal check written by resident #48, dated 12/23/25, reflected the check was addressed to staff member Q from resident #48 for $500, and the check was cashed on 12/21/25 at 5:12 p.m. Review of staff member Q's Relias Education, dated 1/6/26, reflected staff member Q had completed Professional Boundaries education on 12/7/25, and there was abuse, neglect, misappropriation of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275126	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation	1301 E Broadway Missoula, MT 59802

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	funds, and abuse reporting education provided on 10/13/24. Review of the Staff In-Service: Professional Boundaries, dated 1/5/26 - 1/8/26, reflected that staff education was completed on misappropriation of funds, accepting gifts, tips, and gratuities, and professional boundaries. Review of the QAPI agenda, no date, reflected the misappropriation of resident funds was to be addressed with an Action Plan at the upcoming QAPI meeting. The facility identified the concern related to misappropriation of resident funds and immediately protected the resident by suspending staff member Q and instructed him not to have contact with the residents. Notifications were made within the required 24-hour window to law enforcement, APS, and the State Survey Agency. The facility initiated an investigation of the incident and interviewed residents and staff in an effort to identify any other potential victims. No other victims were identified. The facility updated resident #48's care plan and implemented weekly monitoring to ensure sustained compliance. A psychiatric referral was made for resident #48. Education was provided to the facility staff regarding professional boundaries and not accepting money and/or gifts from residents. The incident was added to the facilities QAPI agenda for ongoing monitoring of compliance. Past noncompliance was identified due to the corrective actions taken by the facility.