STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER The Valley Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 601 N 10th St Hamilton, MT 59840	

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide meaningful activities to meet the needs of dementia residents for 6 (#s 1, 4, 5, 9, 12, and 14) of 11 sampled residents with dementia. This deficient practice resulted in residents in the memory unit wandering without activities, remaining in rooms throughout the day, and sitting and staring at blank televisions. Findings include: During an observation on 7/22/26 at 7:55 a.m., residents were sitting in the dining area and the common room. No activities were being provided. Resident #1 sat in a recliner in the common room, scratching her arms repeatedly and staring at the television, which was off. Residents #12 and 14 were sitting in the dining room at tables. Resident #9 was walking around the unit, running into walls and being redirected to walk a different direction. During an observation in the memory unit on 4/22/26 at 10:03 a.m., staff member E stated the activities were canceled due to weather, and the residents would be doing nails and bingo as alternate activities in the afternoon. Staff member E was working on care plans on her computer while sitting at a table with residents. Residents had a newsletter in front of them. Several residents were sitting, staring at the floor or sleeping in their chairs. Residents #4 and 14 were participating in the activity. Residents #5 and #12 were not participating. Resident #1 was in the common room staring at a blank television while sitting in a recliner. Resident #9 was wandering in the hall. Residents in the dining area were then given a word search to complete for points toward prizes. Residents #4 and 14 were actively working on the word search. The other residents continued to sit and not participate. The facility sitters (non-CNAs who watch residents to redirect them to prevent resident-to-resident incidents) sat at the tables but did not attempt to assist residents with the activity. Resident #12 did not speak English and was staring off down the hall. Resident #5 repeatedly stated she would have to get her glasses to see the paper. No one went and got her glasses for her. Resident #1 was wandering the hallways. Staff member E stated she had other duties to attend to in another unit and left.During an interview on 4/22/26 at 10:35 a.m., staff member E stated she was limited on the activities for memory care residents because the staff would get angry and tell her no physical activities or music should be done, because it would get the residents ramped up (excited/agitated) and they would have behaviors. Staff member E stated she had reported this to management, and management agreed that she should not have activities involving music or physical activities. Staff member E stated she was told to limit activities to calming things only. Staff member E stated she felt the residents were left in bed and not taken to activities because it was easier for the staff to manage. Staff member E stated she had many duties outside of the memory care unit activities and had very limited time to spend with residents in the memory care unit. Staff member E stated that the floor staff was supposed to provide activities when she was not present, but the floor staff would not do activities with the residents. Staff member E stated that the floor staff just wanted the residents to sit and be calm and quiet. Staff member E stated she felt the residents' lack of exercise and boredom, for those in the memory care unit, led to more behaviors. Staff member E showed the surveyor the memory care activity calendar and stated the residents did not have activities at all on weekends because there was no activities person working on the weekend, so the calendar showed, Resident Choice Day!!!!During an interview on (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
	275135	A. Building B. Wing	04/23/2026

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The Valley Health and Rehab	601 N 10th St Hamilton, MT 59840

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/22/26 at 11:24 a.m., staff member B stated activities should be patient-centered, calming, and engaging. Staff member B stated that staff member E is still learning what activities she can do in memory care. During an observation on 4/22/26 at 9:53 p.m., resident #1 was sleeping in a recliner in the common area. Resident #19 was sitting in the common room staring at a wall. The television was on and cartoons were playing.During an interview on 4/23/26 at 9:39 a.m., staff member O stated that activities do not usually happen in the memory care unit. Staff member O stated that the activities happening yesterday (4/22/26) and that day were a show just for surveyors.During an interview on 4/23/26 at 11:09 a.m., staff member F stated that staff member E did not stick to doing the activity calendar in the memory care unit most of the time. Staff member F stated she heard complaints from staff regularly, and she heard complaints from residents who would come out of the memory care unit to participate in skilled activities, stating staff member E did not do the activities scheduled. During an interview on 4/23/26 at 11:24 a.m., staff member P stated that staff member E spent most of her time in the memory unit on her computer, not doing any activities. Review of the facility's Activities Calendar Memory Care, dated April 2026, showed:- Resident Choice Day on all Saturdays and Sundays,- Trivia was scheduled for Wednesdays,- Exercise/stretching was scheduled for 19 of 22 weekdays, and - Book club was scheduled for Thursdays. Review of resident #1's MDS, dated [DATE], for the Cognitive Section, reflected that resident #1 had a BIMS of 0 (severely impaired memory).Review of resident #5's MDS Cognitive Section, dated 2/17/26, reflected that resident #5 had a BIMS of 9 (moderately impaired memory).Review of resident #12's MDS Cognitive Section, dated 3/24/26, reflected that resident #12 had a BIMS of 3 (severely impaired memory).Review of resident #14's MDS Cognitive Section, dated 4/1/26, reflected that resident #14 had a BIMS of 5 (severely impaired memory).Review of the facility policy, Activities, dated 1/7/26, showed:- . 2. Activities will be designed with the intent to:a. Enhance the resident's sense of well-being, belonging, and usefulness, . c. Promote or enhance physical activity, .d. Promote or enhance cognition, .g. Reflect residents' interests and age .9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, interviews, and record review, the facility failed to ensure a resident received care for the prevention and treatment of pressure ulcers; failed to complete and document the pressure ulcer/skin assessments, treatments, and services to promote healing, and prevent infection, for 1 (#7) of 3 sampled residents for pressure ulcers/skin care. This deficient practice resulted in skin breakdown and resident #7 developing a large Stage IV pressure ulcer, which became infected, requiring hospitalization and treatment, and the staff reported the resident's behaviors, anxiety, and pain made care difficult. Findings include: Review of [Hospital Name] History and Physical, dated 3/4/26, showed resident #7 admitted to the hospital with increased weakness, numbness of extremities, and inability to walk or complete ADLs. Resident #7 was discharged on 3/10/26 to the skilled nursing facility for a surgical neck wound and rehabilitation. Review of the facility Admit/Readmit Screener, dated 3/10/26, showed resident #7 admitted to the facility with red skin on his right elbow, left neck surgical laminectomy site, and a left shin abrasion. Resident #7 was totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Resident #7 had a Foley catheter.Review of the weekly wound Observation Tool, dated 3/16/26, showed resident #7 had developed right and left buttock moisture-associated skin damage (MASD), and the area was measured and found to be 9.0 cm x 6.5 cm in size on the right buttock and 12.0 cm x 6.0 cm in size on the left buttock. Review of a [Hospital Name] admission note, dated 3/19/26, showed resident #7 was at a post-surgical clinic appointment and noted to be confused and sent to the emergency room. Resident #7 was found to be hyponatremic, and had a sodium level of 113, and had been drinking 10-12 glasses of water a day, per the report. The resident received several doses of Narcan at the hospital. In addition, resident #7 was hypoxic, requiring high-flow oxygen. Review of the [Hospital name] wound care assessment, dated 3/20/26, showed resident #7 admitted to the hospital (3/19/26) with skin breakdown to his sacrum and buttocks. Resident #7 had a non-blanching deep tissue pressure injury, centrally located on the sacrum, with scattered spots of non-blanching purple/maroon, denuded skin, likely a combination of pressure and moisture. The pressure injury was 3.5 cm x 2.5 cm x 0.1 cm in size. Review of a [Hospital name] Progress Note, dated 3/23/26, showed resident #7's labs reflected he had severe protein-calorie malnutrition related to social/environmental circumstances.Review of a [Hospital Name] Wound Care Assessment, dated 3/24/26, showed resident #7's sacral wound had evolved with moist yellow slough, was pink, and a Stage III pressure injury with yeast. Review of facility Admit/Readmit Screener, dated 3/27/26, showed resident #7 returned to the facility with moisture-associated skin damage to his left and right buttocks. No pressure injury was noted on the sacral area. A yeast rash was noted on the buttocks and groin. Review of the facility Weekly Wound Observation Tool, dated 3/30/26, showed resident #7 had scattered ulcerations with moisture-associated skin damage to the left and right buttocks. The measurements were noted as 5.1 cm x 4.3 cm x 0.2 cm. Resident #7 also had a Stage III pressure ulcer to his right medial lower buttock measuring 1.9 cm x 1.5 cm x 0.2 cm. Orders for the skin/pressure ulcer were requested from the physician.Review of the facility Weekly Wound Observation Tool, dated 4/6/26, showed resident #7's Stage III bilateral buttock wounds were now Unstageable and had merged into one large pressure ulcer wound. Resident #7's wound had an odor and moderate purulent drainage (signs of potential infection). The wound measurements were 5.6 cm x 8.0 cm x 0.3 cm. Resident #7 was transferred to the emergency room for a possible infection in the sacral wound.Review of the [Hospital Name] ED to Hosp-admission record, dated 4/6/26, showed resident #7 presented to the emergency room with a fever of 102.6 Fahrenheit, and a blood pressure of 136/102. Resident #7 reported he had a fever for five days while at the facility. Resident #7 had a Large sacral decubitus wound with purulent tissue . with surrounding cellulitis and redness. The radiology results noted a severe sacral decubitus ulcer with erosion nearly to the coccyx with a rim-enhancing gas and fluid collection measuring 4.0 cm. The hospital diagnoses included: abscess, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ulcer, osteomyelitis, cellulitis, sepsis, and a necrotizing soft tissue infection. The physician noted the sacral ulcer was nearly to the bone. General surgery was consulted, and operative debridement was completed. Post-operatively resident #7's wound showed progressive improvement with regular wound assessments and a wound vac. Resident #7's discharge summary noted resident #7 presented to the emergency room with an altered mental status related to metabolic encephalopathy in the context of severe infection and pain from the sacral wound. Resident #7 declined to return to the facility and was sent to an alternate facility for ongoing care and rehabilitation. During an interview on 4/21/26 at 3:08 p.m., NF1 stated that after the resident's first hospitalization with hyponatremia, a pressure ulcer, and malnutrition, he stayed in close contact with the facility management. NF1 stated the staff was frequently frustrated by resident #7's constant need for attention and anxiety. NF1 explained to management that resident #7 had very high anxiety and needed to feel he had some control over things. NF1 also felt that some of the residents' behaviors were related to the low sodium levels, and he improved when he was in the hospital. NF1 stated he repeatedly educated management staff about resident #7's hyperfocus and high anxiety, and he did not understand how the facility staff was supposedly spending so much time with him but did not know he was so sick with the infection and became septic. During an interview on 4/22/26 at 11:50 a.m., staff member B stated the facility was not equipped to manage resident #7's behaviors. Staff member B stated the sacral wound was facility-acquired, and the resident did become obtunded (confused) related to the opioids, and the medication doses were reduced. Staff member B stated she did not know why the facility staff did not note the resident was obtunded before sending him out for an appointment. Staff member B stated she was not aware that resident #7 was drinking 10-12 glasses of water a day until he returned from the hospital. During an interview on 4/22/26 at 4:50 p.m., staff member B stated she did not know where the skin/wound assessments were or why the assessments were not done for resident #7 during the week of 3/31/26 through 4/6/26, which was when resident #7 presented to the hospital with a Stage IV pressure sacral wound and sepsis. Staff member B stated she could not explain why no one reported that the resident's wound was worsening.During an interview on 4/23/26 at 10:31 a.m., staff member I stated she went into the facility to complete the readmission history and physical visit for resident #7. She found he had a fever, and physical therapy had been unable to get him up and moving due to pain. Staff member I stated resident #7's pain medication regimen was intense, and stated, He was gorked out on medications (heavily sedated), and the medication regimen started long before he came to the facility. Staff member I stated there were a lot of opportunities for improvement in the nursing assessments. Staff member I stated she had never taken care of a resident with that level of psych and pain issues before. Staff member I stated the facility could not handle the complex psych needs of resident #7. Review of resident #7's Skin Integrity Care Plan, with a last revision date of 3/27/26, showed:-Potential for Impaired Skin Integrity as evidenced by MASD to sacrum/coccyx with a date initiated of 3/11/26. Interventions included educating resident #7 on skin protection, proper use of pressure-relieving devices, and keeping skin clean and moisturized. Additional interventions included skin evaluations, monitoring the nutritional status, performing skin assessments, and providing skin care according to facility guidelines. The frequency of the tasks was not included on the care plan. The care plan showed:-[Resident #7] has alternation in skin integrity as evidenced by MASD to his R & L buttock, with a date initiated of 3/16/26. Interventions included informing the physician of healed tissue, signs or symptoms of infection, and skin care twice a day, and as needed. -Risk for impaired skin integrity r/t (immobility, incontinence, decreased sensory perception) (surgical and left toe as well as buttocks and coccyx stg III) [sic] with a date initiated of 3/17/26. Interventions included applying barrier cream to the perineal area, assisting with routine turning and repositioning to promote circulation, CNA skin inspections with routine care and report to the nurse, educating the resident on the importance of repositioning, mobility, and nutrition, keeping the skin clean and dry, and for the nurse to perform weekly skin evaluations.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interviews and record reviews, the facility failed to closely monitor and address a resident's lack of bowel movements and provide as-needed medications to treat and prevent constipation, for a resident who had a history of opioid induced constipation and had used constipation medications before admission, for 1 (#7) of 20 sampled residents. This deficient practice resulted in resident #7 having an extensive stool burden. Findings include:Review of [Hospital Name] History and Physical, dated 3/4/26, showed resident #7 admitted to the hospital with a 9.6 cm stool ball noted on the imaging (fecal impaction). Resident #7 was discharged on 3/10/26 to the skilled nursing facility for care of a surgical neck wound and rehabilitation. A review of resident #7's [Hospital Name] physician notes, dated 3/6/26, showed he reported he would not have a bowel movement for up to 5 days, which was possibly due to opioid use.A review of resident #7's [Hospital Name] physician notes, dated 3/9/26, showed under the Subjective section that the physician was . working on balancing between opioid-induced constipation and to many constipation meds. [sic]Review of the facility Admit/Readmit Screener, dated 3/10/26, showed resident #7 admitted to the facility and was totally dependent for bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Resident #7 had a Foley catheter. The document showed resident #7 had normal formed stool, rarely/never depends on laxative.Review of a [Hospital Name] admission note, dated 3/19/26, showed resident #7 was at a post-surgical clinic appointment and was sent to the emergency room due to medical concerns. Resident #7 was found to be hyponatremic and received treatment. During an interview on 4/22/26 at 11:50 a.m., staff member B stated she did not know why the facility staff did not note the resident was confused before sending him out for an appointment. Staff member B stated she was not aware resident #7 was drinking 10-12 glasses of water a day until he returned from the hospital, and he was placed on fluid restrictions. A review of resident #7's nursing progress notes, dated 4/6/26, showed the resident was assessed and found to have a flat abdomen, which was not tender, no indigestion, no vomiting, no bowel sounds present, no nausea, no diarrhea, and no constipation. A review of resident #7's [Hospital Name] notes, dated 4/6/26, which was after the resident was readmitted back to the hospital, showed an Extensive stool burden within the rectum distending the rectum to 8.8 cm with mild rectal wall thickening and perirectal fat stranding concerning for stercoral colitis1.During an interview on 4/22/26 at 4:50 p.m., staff member B stated she could not explain why no one reported that resident #7 had not had a bowel movement in six days, and stated the resident had gone without any as-needed bowel medications.Review of resident #7's Medication Administration Record, dated March - April 2026, showed resident #7 had not received any scheduled or as-needed medications for constipation. Review of resident #7's Bowel documentation, dated 3/11/26 - 4/5/26, showed that resident #7 did not have a bowel movement from 3/29/26 to 4/3/26, and then had diarrhea on 4/4/26, followed by a putty-like stool on 4/5/26. During an interview on 4/23/26 at 11:30 a.m., staff member B stated the facility did not have a policy specific to bowel and bladder management.1Stercoral colitis is inflammation inside your colon caused by fecal impaction (hard impacted stool). Stercoral means feces-related. Colitis means inflammation in your colon (irritation, pain, and swelling). It's a rare but serious complication of severe constipation.Stercoral Colitis: What It Is, Symptoms & Treatment

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to ensure that food items stored in the walk-in cooler were dated and labeled appropriately. This deficient practice placed all residents at risk for foodborne illnesses. Findings include: During an observation on 4/23/26 at 8:06 a.m., the following items were observed in the walk-in cooler:- Two zip-lock bags of slimy, sliced tomatoes, which were not dated. - One gallon zip-lock bag of ground meat, not labeled with the food type or date. - One gallon zip-lock bag of sliced ham, not dated.- One gallon zip-lock bag of sliced roast beef, not dated.- One gallon zip-lock bag of sliced cheese, not dated; and,- A cup of sliced strawberries with no date.During an interview on 4/23/26 at 8:24 a.m., staff member H stated the kitchen staff did see mold on strawberries when the food came in off the truck and would usually try to pick the molded strawberries out. During an interview on 4/23/26 at 8:24 a.m., staff member G stated he was aware of the dating issues and was trying to get staff to date food with and add the use-by dates. Staff member G stated he was re-educating staff and was checking the dates weekly.During an interview on 4/23/26 at 8:36 a.m., staff member B stated that the facility had moldy dinner rolls one day, and she had the staff go around and collect the dinner rolls left from residents who had been served the moldy rolls. Review of the facility's policy, Food Safety Requirements, dated 4/11/25, reflected, .3. iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, facility staff failed to ensure hand hygiene was completed while providing care for a resident's infected wounds/skin for 1 (#16) of 3 sampled residents for wound care. This deficient practice placed all residents receiving care from these staff members at risk of exposure to infectious agents and resident #16 at risk of a spread of skin cellulitis to his right leg. Findings include:During an observation and interview on 4/23/26 at 9:20 a.m. staff members C and J entered the room of resident #16 to assess his reported weeping (edema fluid) and hot (temperature) lower legs. Staff member J removed resident #16's ted hose on the left leg and noted the leg was hot to the touch, and the skin was weeping fluid. Staff member J then moved from the left leg to the right leg, removed the ted hose, and touched and assessed the resident's right leg, noting the skin was dry but intact. Staff member J did not change gloves after touching the resident's bodily fluids on the left leg. Staff member J then had staff member C go to the supply room for new ted hose while she completed hand hygiene and then added lotion to resident #16's legs. Staff member C returned with ted hose and new socks. Staff member C donned gloves and began assisting with placing the new ted hose. Staff member C applied the ted hose to the left leg and noted there was weeping fluid from the skin on the leg. Staff member J applied the ted hose to the right leg. Afterwards, staff member J went to wash her hands and staff member C began to clean up the room, touching the resident's food on his bedside table, grabbing his pillow off his bed, and placing it in the chair where resident #16 was sitting, and putting her gloved hand in her clothing pocket to turn off her ringing cell phone. Staff member C did not perform hand hygiene or change gloves after touching bodily fluids and continued to touch other items in the room. After leaving the room, staff member C stated she did not think of performing hand hygiene when she finished putting the ted hose on the resident. Staff member J stated she thought she had hit all the hand hygiene opportunities, but realized, when this surveyor asked, that she had moved from one leg to the other without hand hygiene. Staff member J stated resident #16 was started on Cipro, an antibiotic, for cellulitis (bacterial skin infection) this morning. Review of the facility's policy, Hand Hygiene Table, dated 4/11/25, reflected that hand hygiene with either soap and water or alcohol-based hand rub should occur during the following opportunities:- . After handling contaminated objects; - . When, during resident care, moving from a contaminated site to a clean body site;- . After handling items potentially contaminated with blood, bodily fluids, secretions, or excretions .