

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 211 N Main St Ennis, MT 59729	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident's representative was notified regarding a fall, a urinary tract infection, and the administration of antibiotics for 1 (#14) of 15 sampled residents. Findings include:</p> <p>During an interview on 5/5/25 at 3:55 p.m., NF4 stated she was frustrated the facility failed to notify her immediately when resident #14 sustained a fall with injury on 3/30/25 at 2:58 a.m., and NF4 stated she was not notified when resident #14 was diagnosed with a urinary tract infection on 4/14/25 and started on antibiotics.</p> <p>Review of resident #14's nursing progress note, dated 3/30/25 at 2:58 a.m., showed the resident had an unwitnessed fall and sustained a skin tear on the back of her right hand and right wrist. The note also showed resident #14 had bruising from her right elbow to her forearm, and down the back of her right hand. The note failed to show the resident's representative was notified regarding the fall with injury.</p> <p>During an interview on 5/8/25 at 8:02 a.m., staff member D stated the nursing staff handled notifying families when a resident fell or had a change in treatment. She believed the resident's fall, which occurred on 3/30/25, was handled by a travel nurse. Staff member D stated NF4 was visiting the resident on 4/13/25 when the facility was trying to obtain a urine specimen for resident #14. Staff member D stated she thought NF4 knew about the infection because she was with the resident when the facility was trying to collect a urine specimen.</p> <p>Review of resident #14's urinalysis, dated 4/14/25, showed the following results:</p> <ul style="list-style-type: none"> <li>- Appearance, turbid (cloudy), normal is clear,</li> <li>- Blood, moderate, normal is negative,</li> <li>- Nitrite, positive, normal is negative,</li> <li>- Leukocyte Esterase, large, normal is negative</li> <li>- WBCs, TNTC (too numerous to count), normal is none,</li> <li>- RBCs, 4-10, normal is none, and</li> </ul> <p>(continued on next page)</p>

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:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Bacteria 3+, normal is none.</p> <p>The specimen was being cultured, results were pending.</p> <p>Review of resident #14's nursing progress note, dated 4/14/25 at 2:39 p.m., showed the laboratory notified the facility of the initial results of the urine test and a culture was pending. The note showed the resident's attending provider was notified of the results.</p> <p>Review of resident #14's nursing progress note, dated 4/14/25 at 4:22 p.m., showed the resident was started on Macrobid for a urinary tract infection.</p> <p>During an interview on 5/8/25 at 8:48 a.m., staff member C stated the resident's representative was aware a urine specimen was being collected to determine if the resident had a urinary tract infection. Staff member C stated the resident's representative was probably not notified about the results of urine test or the fact resident #14 was started on an antibiotic.</p> <p>Review of the facility's policy titled, Family Notification, dated 11/24/15, showed:</p> <p>Notification of changes: A) An accident involving the resident which results in injury .;</p> <p>C) A need to alter treatment significantly; major medication changes .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on observation, interview, and record review, the facility failed to develop, implement, and operationalize a facility policy and procedure for grievances, and ensure grievance information was readily accessible, to include the name and contact information for the grievance official; failed to provide residents with readily available grievance forms for 1 (#18) of 15 sampled residents and failed to provide residents with the option to file grievances anonymously. Findings include:</p> <p>During an observation on 5/8/25 at 8:37 a.m., a walk-through of the facility's common areas was conducted. A resident information board was located at the front entrance to the facility which was enclosed in glass. No documentation was observed on how a resident could file a grievance. Grievance forms were found in one location, in a wall mounted clear file folder, next to the nurse's station. A wingback chair was in front of the wall mounted clear file folder containing grievance forms. No posting of the name and contact information of the grievance official was found, and no secure receptacle or written information was identified to file an anonymous grievance.</p> <p>During an interview on 5/8/25 at 9:52 a.m., resident #18 stated the resident council met monthly in the dining room. Resident #18 stated he was not aware of the location of grievance forms, or whether a grievance could be filed anonymously. Resident #18 stated if he had a problem, he would let staff know, and they would fix it right away, but would like a receptacle in the facility if he needed to file an anonymous grievance.</p> <p>During an interview on 5/8/25 at 11:00 a.m., staff member D stated grievance forms were located on the wall next to the nurse's station. Staff member D stated the wingback chair blocking access to the grievance forms was not usually placed in front of the grievance forms, and she did not know why it was there. Staff member D stated a resident confined to a wheelchair would have a difficult time accessing a grievance form due to the height and location of the forms. Staff member D stated residents can file an anonymous grievance by placing the form under her office door or in the wall mounted clear file folder next to her office door. Staff member D stated the facility did not have a specific secure receptacle for residents to file grievances anonymously. Staff member D stated the resident bulletin board, located at the entrance to the facility, should have information on how a resident would file a grievance but could not explain why the information was missing at the time of her interview.</p> <p>A review of the facility's policy titled, Grievance/Complaint Filing, dated revision April 2017, showed the following:</p> <p>Policy Interpretation and Implementation</p> <p>. 4. Upon admission, residents are provided with written information on how to file a grievance or complaint. A copy of our grievance/complaint procedure is posted on the resident bulletin board.</p> <p>5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously.</p> <p>6. The contact information for the individual(s) with whom a grievance may be filed is provided to the resident and/or representative upon admission.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. The administrator has delegated the responsibility of grievance and/or complaint investigation to the grievance officer who is Social Services and can be contacted by all staff or calling facility at [facility phone number].</p> <p>. 13. If the grievance was filed anonymously, the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance(s) and report the findings. The grievance officer will reiterate to the resident that it is against facility policy and federal regulations to discriminate or sanction a resident who has filed or verbalized a complaint against the facility, and that his or her rights to be free of discrimination or reprisal will be protected.</p> <p>. 15. This policy will be provided to the resident or the resident's representative upon request.</p> <p>A review of a facility document titled, Resident Handbook, not dated, showed the following:</p> <p><b>GRIEVANCES/RECOMMENDATIONS</b></p> <p>A resident has the right to voice grievances and prompt efforts will be made to resolve grievances a resident may have, including those with respect to the behavior of staff and other residents. [Facility Name] also welcomes recommendations from residents and families. Please feel free to talk to the Charge Nurse or Social Services about any suggestions you might have.</p> <p>The facility failed to show residents were provided with written information on how to file a grievance upon admission, failed to post the facility grievance policy and procedure on the resident bulletin board, failed to provide the name and contact information of the grievance officer, failed to provide access to readily available grievance forms, and failed to provide a secured receptacle for a resident to file an anonymous grievance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on observation, interview, and record review, the facility failed to perform and document a complete resident assessment prior to the use of bed rails as a restraint for 1 (#7); failed to complete and document a resident assessment prior to the use of a scoop mattress for 1 (#17); and failed to perform and document ongoing monitoring of the appropriate use of assistive devices which could be considered a restraint for 2 (#14 and #17) of 15 sampled residents. These failures increase the risk of injury for the residents. Findings include:</p> <p>1. During an observation and interview on 5/5/25 at 2:04 p.m., resident #7 was in his room seated in his wheelchair. The resident's bed was noted to have upper half bed rails placed and pulled up on both sides of the bed. Resident #7 stated he used the bed rails a lot. Resident #7 stated his left side was paralyzed from a stroke. The second and third fingers of his left hand were contracted with limited range of motion.</p> <p>During an observation and interview on 5/7/25 at 1:32 p.m., resident #7 was seated in his wheelchair next to his bed. Both upper bed rails were seen in the up position. When the resident was asked to lower the left bed rail, resident #7 was unable to pull the pin so the rail could be lowered. The resident stated he did not have the strength or coordination to pull the pin which allowed the rail to be lowered. The resident and NF5 stated the bed rails were used to help him move from side to side in the bed and prevented him from accidentally rolling out of bed. NF5 stated if the bed rails were removed, she was concerned the resident would roll out of the bed and be injured when he fell to the floor. Resident #7 stated the bed rails prevented him from getting out of bed.</p> <p>During an interview on 5/8/25 at 8:23 a.m., staff member B stated when a resident or family requested the use of bed rails, the resident was assessed and IDT discussed the situation. If the bed rails were determined to be appropriate, an order from the provider was obtained before the bed rails were installed on the bed. Staff member B stated residents should be assessed at least quarterly for continued appropriateness of the use of bed rails.</p> <p>During an interview on 5/8/25 at 8:48 a.m., staff member A stated she had been working on developing the assessments to be used when a resident used a restraint or assistive device such as bed rails for improved bed mobility. Staff member A stated the EHR system did not come with the appropriate forms needed for resident assessment, risk and benefit discussions, or informed consent.</p> <p>Review of resident #7's physician order, dated 10/29/23 and 5/5/25, showed orders for the use of bed rails on both sides for mobility while in bed.</p> <p>Review of resident #7's Quarterly Restraint Evaluation, dated 8/7/24, failed to show if the bed rails met the criteria for a restraint and failed to show if the risks and benefits were discussed with the resident and his representative.</p> <p>Review of resident #7's Assistive Device/Restraint Initial Evaluation, dated 11/5/24 and 2/3/25, failed to show whether or not the resident was able to easily remove the bed rail independently. The assessment showed the bed rails did not impact the resident's freedom of movement. This contradicted NF5's statement that the bed rails prevented the resident from rolling out of bed and falling to the floor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy titled, Side Rails and Restraints, dated 4/9/24, showed restraints were not for discipline, staff convenience or as a fall prevention strategy. Restraints were defined as, . any manual method or physical or mechanical device, . the individual cannot remove easily, which restricts freedom of movement . and The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e. side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. [sic]</p> <p>2. During an observation and interview on 5/7/25 at 11:56 a.m., resident #17 was seen up in her wheelchair out in the hallway. Resident #17 stated she has had the scoop mattress on her bed since she was admitted (2/6/24). Resident #17 stated she has been working with therapy to learn how to get out of bed on her own and stated the scoop mattress did not restrict her movement while in bed.</p> <p>During an observation on 5/7/25 at 12:55 p.m., resident #17 demonstrated her ability to turn to her side and sit up on the edge of the bed, independently, thereby demonstrating the scoop mattress did not limit the resident's freedom of movement.</p> <p>Review of resident #17's Quarterly MDS Assessment, with an ARD date of 10/30/24, showed the resident was coded as using an Other restraint on a daily basis.</p> <p>Review of resident #17's Annual MDS Assessment, with an ARD of 1/29/25, showed no restraints of any kind were in place during the observation period.</p> <p>Review of resident #17's Quarterly MDS Assessment, with an ARD date of 4/16/25, showed the resident was using both side rails and the assessment was coded as an Other restraint on a daily basis.</p> <p>Review of resident #17's EHR failed to show a resident assessment was completed prior to the initial use of a scoop mattress (on 10/30/24). The EHR failed to show ongoing monitoring of the appropriate use of a scoop mattress from 5/8/24 to 5/6/25.</p> <p>Review of resident #17's Assistive Device/Restraint evaluation, dated 5/6/25, showed the resident was using a scoop mattress because of poor body core control. The evaluation also showed, Not used as a restraint but helps with transfers and positing [sic] in bed. The evaluation failed to show whether or not the scoop mattress limited the resident's freedom of movement.</p> <p>3. During an observation on 5/5/25 at 3:29 p.m., resident #14 was lying in her bed watching television. Both of the upper bed rails were in the up position. When asked, the resident stated she liked the bedrails because they kept her from falling out of bed.</p> <p>During an interview on 5/5/25 at 3:55 p.m., NF4 stated resident #14 had a tendency to sleep close to the edge of the bed. Therefore, having the bed rails up helped the resident feel safe in her bed.</p> <p>During an observation and interview on 5/7/25 at 12:48 p.m., resident #14 stated the bed rails are, . so I don't roll out of bed. Staff member I asked resident #14 to sit on the edge of the bed and then stand up. Resident #14 was able to perform this activity independently. Staff member I stated the bed rails do not limit the resident's bed mobility or ability to get out of bed unaided.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #14's MDS assessments showed the following:</p> <ul style="list-style-type: none"> <li>- Quarterly MDS, with an ARD of 7/31/24, showed bed rails were used daily.</li> <li>- Quarterly MDS, with an ARD of 10/30/24, showed bed rails were used daily.</li> <li>- Annual MDS, with an ARD of 1/29/25, showed bed rails were used daily.</li> <li>- Quarterly MDS, with an ARD of 4/16/25, showed bedrails were used daily.</li> </ul> <p>Review of resident #14's Assistive Device/Restraint Evaluation, dated 2/1/25, showed the bed rails were used as a mobility aid and did not limit her movement.</p> <p>Review of resident #14's EHR failed to show any Assistive Device/Restraint Evaluations were documented between 5/6/24 and 1/31/25.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 211 N Main St Ennis, MT 59729	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure assistive devices were not coded incorrectly as restraints for 2 (#s 14 and 17) of 15 sampled residents. Findings include:</p> <p>1. During an observation and interview on 5/7/25 at 11:56 a.m., resident #17 was seen up in her wheelchair out in the hallway. Resident #17 stated she has had the scoop mattress since she was admitted (2/6/24). Resident #17 stated she has been working with therapy to learn how to get out of bed on her own and stated the scoop mattress did not restrict her movement while in bed. No bed rails were seen on the resident's bed.</p> <p>During an observation on 5/7/25 at 12:55 p.m., resident #17 demonstrated her ability to turn to her side and sit up on the edge of the bed, independently, thereby demonstrating the scoop mattress did not limit the resident's freedom of movement and was not considered a restraint.</p> <p>Review of resident #17's Assistive Device/Restraint evaluation, dated 5/6/25, showed the resident was using a scoop mattress because of poor body core control. The evaluation also showed, Not used as a restraint but helps with transfers and posing [sic] in bed.</p> <p>Review of resident #17's Quarterly MDS Assessment, with an ARD date of 10/30/24, showed the resident was using an Other restraint on a daily basis.</p> <p>Review of resident #17's Quarterly MDS Assessment, with an ARD date of 4/16/25, showed the resident was using both side rails and an Other restraint on a daily basis.</p> <p>Resident #17's ability to get out of bed unaided should have resulted in the determination the scoop mattress was not a restraint and the mattress should not have been coded as such on the MDS assessment.</p> <p>2. During an observation and interview on 5/7/25 at 12:48 p.m., resident #14 stated the bed rails were, . so I don't roll out of bed. Staff member I asked resident #14 to sit on the edge of the bed and then stand up. Resident #14 was able to perform this activity independently. Staff member I stated the bed rails did not limit the resident's bed mobility or ability to get out of bed unaided.</p> <p>Review of resident #14's Assistive Device/Restraint Evaluation, dated 2/1/25, showed the bed rails were used as a mobility aid and did not limit her movement.</p> <p>Review of resident #14's MDS assessments showed the following:</p> <ul style="list-style-type: none"> <li>- Quarterly MDS, with an ARD of 7/31/24, showed bed rails were used daily.</li> <li>- Quarterly MDS, with an ARD of 10/30/24, showed bed rails were used daily.</li> <li>- Annual MDS, with an ARD of 1/29/25, showed bed rails were used daily.</li> <li>- Quarterly MDS, with an ARD of 4/16/25, showed bed rails were used daily.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's ability to get out of bed unaided, and the presence of bed rails did not limit her mobility, and resulted in the determination the bed rails were not a restraint and should not have been coded as such on the MDS assessments.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>Based on observation, interview, and record review, the facility failed to perform and document a complete resident assessment for the use of bed rails as a restraint for 1 (#7) of 15 sampled residents. This failure placed the resident at increased risk for injury related to the use of bed rails which met the definition of a restraint. Findings include:</p> <p>During an observation and interview on 5/5/25 at 2:04 p.m., resident #7 was in his room seated in his wheelchair. The resident's bed was noted to have bed rails on both sides of the bed in the up position. Resident #7 stated he used the bed rails a lot. Resident #7 stated his left side was paralyzed from a stroke. The second and third fingers of his left hand were contracted with limited range of motion.</p> <p>During an observation and interview on 5/7/25 at 1:32 p.m., resident #7 was seated in his wheelchair next to his bed. The bed rails were seen in the up position. When asked to lower the left bed rail, resident #7 was unable to pull the pin so the rail could be lowered. The resident stated he did not have the strength or coordination to pull the pin which allowed the rail to be lowered. NF5 stated the facility had discussed the risks and benefits associated with the use of bed rails. The resident and NF5 stated the bed rails were used to help him move from side to side in the bed and prevented him from accidentally rolling out of bed. NF5 stated if the bed rails were removed, she was concerned he would roll out of the bed and be injured when he fell to the floor. Resident #7 stated the bed rails prevented him from getting out of bed.</p> <p>During an interview on 5/8/25 at 8:23 a.m., staff member B stated when a resident or family requested the use of bed rails, the resident was assessed and IDT discussed the situation. If the bed rails were determined to be appropriate, an order from the provider was obtained before the bed rails were installed on the bed. Staff member B stated the resident should be assessed at least quarterly for continued appropriateness of the use of bed rails.</p> <p>During an interview on 5/8/25 at 8:48 a.m., staff member A stated she had been working on developing the assessments to be used when a resident used a restraint or assistive device such as bed rails for improved bed mobility. Staff member A stated the EHR system did not come with the appropriate forms needed for resident assessment, risk and benefit discussions, or informed consent.</p> <p>Review of resident #7's physician order, dated 10/29/23 and 5/5/25, showed orders for the use of bed rails on both sides for mobility while in bed.</p> <p>Review of resident #7's Assistive Device/Restraint Initial Evaluation, dated 11/5/24, failed to show the bed rails were a restraint because the resident was not able to easily remove the bed rail independently. The assessment also failed to show the bed rails limited the resident's movement by preventing him from getting out of bed when the rails were in the up position.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Side Rails and Restraints, dated 4/9/24, showed restraints were not for discipline, staff convenience or as a fall prevention strategy. Restraints were defined as, . any manual method or physical or mechanical device, . the individual cannot remove easily, which restricts freedom of movement . and The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e. side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on interview and record review, the facility failed to ensure competent nursing staff were able to provide nursing service for on time medication administration for 1 (#8), and failed to meet a resident's physical and psychosocial needs, for 1 (#16) of 15 sampled residents. Findings include:</p> <p>1. During an interview on 5/6/25 at 9:08 a.m., resident #16 stated there had been an issue with a travel nurse who had an attitude. Resident #16 stated the nurse was gone after only a few days. Resident #16 stated other residents had voiced concern and complained about the same travel nurse and had issues with the nurse's attitude and timeliness of completing care. Resident #16 was hesitant to provide additional detail regarding specific incidents.</p> <p>During an interview on 5/8/25 at 11:08 a.m., staff member B stated she was responsible for covering any call-offs by nurses. Staff member B stated she helped cover for medication passes if a traveler needed assistance. This was to help avoid medications being administered late. Staff member B stated she was on-call and available all the time. Staff member B stated some travel nursing staff had self-reported when they were late with administering medications, but some of the travel nurses did not reach out for assistance, which resulted in late medication administrations. Staff member B stated she had to let some travelers go recently due to issues with late medication administration. Staff member B stated she was asked recently to start using medication administration competencies for nursing orientation to the facility. Staff member B stated there was one regular nurse employed full-time. The rest of the nursing staff positions were filled by travelers. Staff member B stated the facility had a hard time with nurse recruitment because of the facility's location, and the cost of living in the area.</p> <p>Review of resident council meeting minutes, dated 3/13/25, showed multiple residents complained about the care provided by travel nurses.</p> <p>2. Review of resident #8's medication administration audit report, dated 4/13/25, showed the administration of Lisinopril 20 mg, Cystex urinary health liquid, Miralax 17 gram packet, and acetaminophen 1000 mg was at 10:31 a.m. The scheduled administration time should have been 7:00 a.m.</p> <p>Review of resident #8's medication administration audit report, dated 4/26/25, showed administration of Lisinopril 20 mg at 10:10 a.m., with a scheduled administration time of 7:00 a.m.</p> <p>Review of a facility policy titled, Medication Administration &amp; Schedule Times of Medication Administration, revision date 11/27/23, showed:</p> <p>. Medication pass process will focus on the establish standards of practice that include the seven rights of medication administration.</p> <p>Right resident</p> <p>Right drug</p> <p>Right does (dose)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Right route</p> <p>Right time</p> <p>Right documentation</p> <p>Right evaluation of efficacy of the medication .</p> <p>Medications are scheduled based on the doctor's order, they are input into point click care, online electronic administration record, and given per doctor's orders. There is a one-hour window before and a one-hour window after the scheduled time of medication administration before the medication is considered late. [sic]</p> <p>Review of a facility document titled, Facility Assessment, revision date of 8/2024, showed the staffing plan was for 6.5 (FTE's) for licensed nurses providing direct care. The facility made a good faith effort to provide the training, education, and competencies necessary for the level and types of support and care needed for the resident population. Part of the new hire process for both core staff and contract staff was competencies with return demonstration as part of the requirement. Yearly competencies were completed to ensure staff remained proficient in their practices and met the needs of the resident population.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure foods were dated and labeled when opened, disposed of when expired, and failed to maintain a clean kitchen environment. This failure increased the risk of unsanitary conditions and foodborne illnesses, for individuals consuming food stored in the facility kitchen and resident refrigerator, and from food prepared in the facility kitchen. Findings include:</p> <p>1. Unlabeled/Undated/Expired Foods</p> <p>During an observation on 5/5/25 at 1:03 p.m., the following items were seen in the dry storage area:</p> <ul style="list-style-type: none"> <li>- one bag of vermicelli pasta, open and undated,</li> <li>- one box of vanilla maple cereal, open and undated,</li> <li>- one box of Jello mix, expiration date of 2022,</li> <li>- one box of Jello mix, expiration date of 2023,</li> <li>- one bottle of Karo corn syrup, best by date of 2024,</li> <li>- one bag of opened Chile de arbol powder, best by date of 7/1/23,</li> <li>- one open and undated bag of Knorr vegetable recipe mix, best by date of 2023,</li> <li>- one box of Honey Maid graham crackers, best by date of 10/31/24,</li> <li>- several small bags of [NAME] cheese popcorn, with a best by date of 4/7/25,</li> <li>- several small bags of [NAME] chips with a best by date of 3/17/25, and</li> <li>- one bag of Lays BBQ chips, opened and undated.</li> </ul> <p>During an observation on 5/5/25 at 1:21 p.m., the following items were seen in the walk-in refrigerator:</p> <ul style="list-style-type: none"> <li>- one bottle of Catalina dressing, use by date of 7/2024,</li> <li>- one bottle of Sparkling Ice, open and undated,</li> <li>- one bottle of General Tso's sauce open, with a date of 7/17, and a best by date of 4/2025,</li> <li>- one bottle of Snapple iced tea, opened and not dated,</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- two containers of cottage cheese, one opened and undated, both with a best by date of 4/30/25, and</p> <p>- one bottle of horseradish, best by date of 4/29/25.</p> <p>During an observation on 5/6/25 at 2:33 p.m., the following items were identified in the resident refrigerator:</p> <p>- one bag of prunes, opened, with no date or resident name,</p> <p>- one Dannon Light and Fit strawberry yogurt, with an expiration date of 3/20/25, and</p> <p>- one bottle of a Premier Protein chocolate shake, opened and not labeled or dated.</p> <p>During an interview on 5/7/25 at 2:09 p.m., staff member F stated food inventory was rotated on how items were placed, based on first in, first out. Staff member F stated dietary staff tried to do a food inventory audit every month to remove outdated items.</p> <p>During an observation on 5/8/25 at 7:41 a.m., the walk-in refrigerator had slices of pulled pork and roast beef slices in plastic bags with pink colored fluid pooling on the bottom of the bag with pulled on 5/7 written on them, sitting on shelves above non-meat foods.</p> <p>During an observation on 5/8/25 at 9:06 a.m., a bag of Sweetheart white bread, with a best by date of 4/30/25, was sitting on a counter beside other packages of bread, near the three-compartment sink.</p> <p>Review of a facility document titled, Food Storage, undated, showed:</p> <p>. All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods.</p> <p>d. Date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed . or discarded will be visible on all high risk food .</p> <p>f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded.</p> <p>2. Clean Kitchen Environment</p> <p>a. Kitchen Fan</p> <p>During an observation on 5/5/25 at 1:43 p.m., an oscillating fan was blowing air on a shelf with racks of drying dishes, and gray dust was visible on the spokes and back of the fan.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/7/25 at 11:53 a.m., staff member H stated the fan blowing on the racks of drying dishes needed to be cleaned and dusted. Staff member H stated it might have been on the list of deep cleaning to be done. Staff member H stated whoever noticed it was getting dirty or dusty would usually clean it whenever there was time. Staff member H stated, I don't think that task is on there, there's no set cleaning schedule for it (fan).</p> <p>During an interview on 5/7/25 at 2:14 p.m., staff member F stated there is a list of cleaning tasks for dietary employees, and the checklist needed to be completed by whoever was doing the cleaning.</p> <p>During an observation on 5/8/25 at 9:03 a.m., an oscillating fan was blowing air on dishes drying on shelf after being washed. The outer surface of the fan had gray dust on its spokes, creating the risk of dust blowing on the drying, clean dishes placed on the shelf.</p> <p>b. Floor Drain</p> <p>During an observation on 5/5/25 at 1:45 p.m., a floor drain was covered with a damp white towel, in front of a three-compartment sink.</p> <p>During an observation on 5/7/25 at 11:42 a.m., the floor drain in front of a three-compartment sink was not covered, with visible peeling and cracking on the flooring where the drain was set in the floor. There were cracks and openings around where the drain which were unsealed.</p> <p>During an interview on 5/7/25 at 11:51 a.m., staff member H stated the floor drain had been like that for over a year.</p> <p>During an interview on 5/7/25 at 2:16 p.m., staff member F stated a service company, Roto Rooter, came to the facility last year and inspected the floor drain in the kitchen. Staff member F stated there had been plans to renovate and remodel the kitchen for several years. Staff member F stated the floor drain was usually covered, and the three-compartment sink was only used as a back-up, if the dishwasher was down. Staff member F stated there were times an odor was noticed near the floor drain.</p> <p>During an interview on 5/8/25 at 9:27 a.m., staff member E stated the facility had the kitchen floor drain inspected at the end of last year (2024). Staff member E stated the facility was waiting on someone to come and service it, but, no one wants to come out to [Town Name] to fix it. Staff member E stated the floor drain area would require cutting into the floor to replace a pipe. Staff member E stated, We just haven't got anyone to come out and fix it (floor drain), places we have tried were unavailable too.</p> <p>Review of an email sent to staff member A, dated 1/10/25, showed:</p> <p>One of the things the USDA told us they need to proceed with the project is to have the sewer line (the one in the kitchen) scoped to see if it needs to be repaired/is usable/something wrong with the trap. I understand RotoRooter is who has been used in the past. [sic]</p> <p>Review of an email sent by staff member F to staff member A, dated 1/16/25, showed:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Roto roter found there to be a crack in the pipe, likely due to the ground settling at the drain, allowing water that should be holding in the pipe to seep through the crack. A section of the materials around the floor drain will need to be removed to complete repairs. [sic]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	

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)
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a hospice resident's pain was managed effectively and consistently, to lessen a resident's intermittent pain level, for 1 (#11) of 15 sampled residents. This increased the risk of causing unnecessary pain and/or discomfort. Findings include:</p> <p>During an observation and interview on 5/6/25 at 3:08 p.m., NF6 was sitting in a chair beside resident #11's recliner, holding resident #11's hand as resident #11 was resting. NF6 stated resident #11 received a regular dose of ibuprofen and Tylenol per hospice orders. NF6 stated she had a concern with nurses not giving morphine for pain relief until waiting one full hour for the dose of ibuprofen or Tylenol to kick in. NF6 stated resident #11 did not take medications for anxiety or any other psychotropics to assist with comfort needs. NF6 stated resident #11 had never taken many types of medications for pain, and did not always ask for pain medication. NF6 stated she spoke with staff member B about the pain medication timing. NF6 stated pain medication and its timing would be discussed in an upcoming care conference meeting.</p> <p>During an interview on 5/8/25 at 11:19 a.m., staff member B stated facility nursing staff was responsible for administering medications for residents receiving hospice services. Staff member B stated she had discussed NF6's concern about the timing of morphine doses given to resident #11. Staff member B stated nurses administering pain medications needed to complete an assessment of the resident. Staff member B stated pain medications were given in part based on a nursing assessment, not only due to a request. Staff member B stated it was general practice to start low with pain medications. Staff member B stated using a medication like acetaminophen first was common, and then administering stronger pain medication, if needed. Staff member B stated she thought as needed morphine was to be used mainly during the later stages of resident #11's condition. Staff member B stated the order needed to be discussed in a meeting, and with hospice staff to clarify. Staff member B stated pain medication for resident #11 was administered based on provider orders, nursing assessment, and personalized care plan.</p> <p>Review of resident #11's medication administration record, dated February 2025, showed, Acetaminophen Oral Liquid Give 15 ml by mouth every 6 hours as needed for pain -Start Date- 1/23/2025 was ordered, and no doses were documented as being administered for pain.</p> <p>Review of resident #11's medication administration record, dated March 2025, showed:</p> <p>Acetaminophen Oral Liquid . Give 15 ml by mouth every 6 hours as needed for pain -Start Date- 01/23/2025 was documented as being administered on 3/1, 3/2, 3/7, 3/24, 3/27, 3/28, with no follow-up pain level being documented for the doses administered, and also showed:</p> <p>Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML . Give 0.25 ml by mouth every 1 hours as needed for Shortness of Breath; Pain -Start Date- 03/02/2025 was administered on 3/2, 3/7, 3/27, 3/28, and 3/31.</p> <p>Review of resident #11's nursing progress note, dated 3/17/25 at 5:48 p.m. showed, Pain monitoring order put in place after interview with resident and review of medication mar and pain assessment.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	

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)
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #11's treatment administration record, dated 3/17/25, showed pain level was to be monitored using a pain scale 0-10, two times a day. It showed: My acceptable pain level is (4).</p> <p>Review of resident #11's treatment administration records for January and February 2025 did not show any pain level monitoring documented.</p> <p>Review of a facility document titled, Individual Narcotic Log, dated 1/30/25, showed resident #11 received morphine 0.25 mg as needed on six occasions since the medication was received by the facility on 1/30/25. The last dose documented on the form was on 4/7/25.</p> <p>1. Review of resident #11's nursing progress note, dated 3/2/25 at 12:39 a.m., showed:</p> <p>Pt was having pain now in her shoulders from fall and says her head was starting to hurt again. Pt has elevated pulse of 111. Prn Tylenol was given previously for pain and was effective for a while and pain has returned in head and has new onset of pain in shoulders. The as needed morphine was not administered to resident #11 until two doses of acetaminophen had been given.</p> <p>Review of resident #11's nursing progress note, dated 3/7/25 at 9:44 p.m., showed morphine was administered after acetaminophen was given at 9:17 p.m.</p> <p>Review of resident #11's nursing progress note, dated 3/27/25 at 2:22 p.m., showed, Resident c/o shoulder pain, rating pain 5/10 (one to 10 pain scale). Resident wincing when moved and the head of bed adjusted. [Family Member] requesting pain medication for resident.</p> <p>Review of resident #11's nursing progress note, dated 3/27/25 at 3:30 p.m., showed, Resident continuing to c/o pain to her shoulders after Tylenol was given. Resident rating pain at a 5/10 when asked. [Family Member] requesting morphine and reported that resident was wincing and grimacing while laying in bed.</p> <p>Review of resident #11's nursing progress notes, dated 3/28/25 at 1:15 a.m., showed resident #11 received acetaminophen. Morphine was administered by the nurse after resident #11 requested morphine for continuing pain.</p> <p>Review of resident #11's nursing progress note, documented by staff member B, dated 3/31/25, showed:</p> <p>Left message to visit with [NF6] regarding pain medication and routine after discussion with [Attending Physician] will call one of the other POAs. Phoned [Family Member] another POA regarding the plan to restart ibuprofen at night to keep pain at bay. Wanted to see if we could use another pain medication without going right to morphine. [Family Member] agreed. Then [NF6] came into my office to discuss, she said they signed up with hospice services so that her [resident #11] could have her pain managed as she continues to decline and felt it is appropriate to give morphine when staff feel the need without asking the MD. Told her we would get clarifications from the doctor to give without it being an end of life situation. [NF6] said 'this is end of life'. [sic]</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 211 N Main St Ennis, MT 59729	
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)		
<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #11's nursing progress note, dated 3/31/25, showed, Resident c/o left shoulder pain and rating pain 7/10 (one to 10 pain scale). Resident grimacing and moaning when moved with the lift. Called and spoke with [Attending Physician] who gave a verbal okay to give the morphine for pain.</p> <p>6. Review of resident #11's nursing progress note, dated 4/7/25 at 3:24 a.m. showed:</p> <p>Note Text : Monitor pain using pain scale 1-10. My acceptable pain level is (4). If pain over acceptable Level: follow pain management plan or follow up with provider and Progress Note. every shift for Pain Resident woke up with 10/10 allover pain around 0200. Medicated with morphine 0.25 with relief. Resident is now able to sleep comfortably. [sic]</p> <p>Review of a facility document titled, Comprehensive Hospice/Facility Plan of Care, dated 2/18/25, showed:</p> <p>. Hospice elected on 1/28/25 initiating a hospice plan of care 'appropriate medical and nursing care for residents with advanced and progressive disease for whom the focus of care is controlling pain and symptoms while maintaining optimal quality of life' .</p> <p>Pain . Goal: Pain will be relieved or reduced .</p> <p>Intervention: Facility to administer analgesics as ordered .</p> <p>Assess characteristics of pain: location, severity, type, frequency .</p> <p>Evaluate pt's response to pain medication .</p> <p>Review of a facility document titled, Hospice/Comfort Care, dated 5/11/18, showed:</p> <p>.The goal is to prevent or relieve suffering as much as possible while still managing symptoms with less aggressive measures. This is done so while maintaining the resident's wishes, providing education to the resident's family, receiving provider input and creating an interdisciplinary, individual care plan for the resident. The resident may choose to stay on certain medications for comfort . Some residents do quite well with status and may stay at this level for long periods of time. [sic]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  275136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Madison Valley Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  211 N Main St Ennis, MT 59729	

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)
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of the freezers was adequately maintained, in safe operating condition, in the kitchen. This failure increased the risk of foodborne illnesses for individuals consuming food prepared from the facility kitchen. Findings include:</p> <p>During an observation on 5/5/25 at 1:33 p.m., the bottom level shelves of the kitchen entry way freezer had two cardboard signs reading, Do Not Use. Food items were stored on all shelves of the freezer except the bottom level.</p> <p>During an interview on 5/7/25 at 2:56 p.m., staff member F stated there were plans to renovate and remodel the kitchen. Staff member F stated the freezer needed to be replaced. Staff member F stated it had been put on hold due to the planned renovation and remodel of the kitchen. Staff member F stated the cardboard signs reading Do Not Use were placed on the entry way bottom shelf of the freezer to remind staff not to put food items there. Staff member F stated when items were placed there, it caused freezer burn. This resulted in food sometimes needing to be thrown out when staff forgot about not putting things on the bottom shelves. Staff member F stated there had been some issues with the seal to the freezer door failing to maintain the frozen state of the foods placed on the bottom shelves.</p> <p>Review of the U.S. Food and Drug Administration 2022 Food Code, showed:</p> <p>. EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.</p> <p>The freezer equipment should be designed and maintained to keep foods in the frozen state. Corrective action should be taken if the storage or display unit loses power or otherwise fails. [sic]</p> <p>Reference: United States Food and Drug Administration. (2022). 2022 Food Code. <a href="https://www.fda.gov/food/fda-food-code/food-code-2022">https://www.fda.gov/food/fda-food-code/food-code-2022</a></p>