STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275160	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Rehabilitation and Nursing LLC	1050 Grand Dr Bigfork, MT 59911

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 the interview and record review, the facility failed to prevent verbal abuse by a staff member who was fairly new to the facility position, and who had already received further education due to communication concerns while working with residents, but the staff member then verbally abused 1 (#3) resident of 5 sampled residents. This reflected the facility's abuse prevention program was not effective to prevent abuse for this resident. Findings include:Review of facility reported incident investigation showed on 4/23/26, [Resident #3] reported to [staff member C] that an incident occurred the previous evening on [4/22/26] at approximately 8:30 p.m. [Resident #3] stated that while receiving assistance with bedtime care, Certified Nursing Assistant (CNA) [NF4] spoke to her using what she described as ?gruff' language. The resident did not wish to have NF4 provide care to her any longer. The investigation showed a witness confirmed resident #3's allegation, and NF4 was terminated for abuse.During an interview on 5/6/26 at 11:37 a.m., staff member C stated resident #3 told her during a care session that NF2, the night before, had said things to her she did not like, but could not remember the specific words. Staff member C helped resident #3 write a grievance, and staff member C gave the grievance to the DON. Staff member C stated she helped with the interview of a resident witness who said they saw resident #3 upset after an interaction with NF2.During an interview on 5/7/26 at 9:39 a.m., staff member B stated she and the administrator were informed of the allegation for resident #3. Through the investigation process, the facility confirmed the allegation of verbal abuse by NF2 from a resident witness. NF4 was a new hire of only a few weeks and had all the abuse and resident rights training at orientation. Staff member B stated she had prior educational conversations with NF2 about the employee's approach with residents, being rude, and being in a hurry with communication, before the allegation. NF4 was terminated following the investigation for abuse.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to document the required information for a resident discharge from the facility for 1 (#2) of 5 sampled residents. Findings include:During an interview on 5/7/26 at 9:08 a.m., staff member B stated the discharge for resident #2 was planned. Staff member B stated she was transferred to another facility by her family, although the documentation (in the EHR) does not show it. Staff member B stated the documentation expectation for a discharge would include a discharge planning assessment with the required discharge information, and on discharge, a discharge summary documented in the nurse's progress notes.Review of resident #2's EHR census tab showed she was discharged from the facility on 2/18/26.Review of resident #2's Nurse Progress Notes for February 2026 showed, Resident left at this time via [local transport company]. [Family member] was here to pack up her personal belongings. Medications sent with her. No other documentation was completed or found in the medical record to show the discharge was planned, where the resident was discharged to, a discharge summary, or communication to the other facility. Review of the facility policy, Transfer and Discharge (including AMA), showed the facility was to send pertinent care-related information and document with a discharge summary recapitulating the resident's stay.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review the facility failed to provide regular bathing to 1 (#2) of 5 sampled residents. Findings include:During an interview on 5/6/26 at 2:06 p.m., staff member E stated the residents were bathed at least once a week, with several scheduled twice a week. Staff member E stated they filled out forms for any resident refusals after several attempts, and the nurse on duty had to sign off.During an interview on 5/7/26 at 8:27 a.m., staff member B stated she might have had the old shower sheets (documents) for January and February (2026) for resident #2, but the timeframe was when the facility was implementing new forms to document their bathing process.During an interview on 5/7/26 at 8:37 a.m., staff member B stated she looked through forms and could not find any documentation showing resident #2 had showers from 1/10/26 until 2/2/26, per the EHR documentation.Review of resident #2's bathing documentation from January through February 2026 showed resident #2 did not receive bathing from 1/11/26 until 2/2/26; for 22 days.