STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27A052	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montana Mental Health Nursing Home	800 Casino Creek Dr Lewistown, MT 59457

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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interviews and record reviews, leadership staff failed to ensure residents were free from neglect of care and utilize or follow an effective system to identify, address, and correct concerns pertaining to staff member R's actions and failure to complete duties assigned when on shift and providing resident care, as to ensure residents were not neglected, and this failure affected 11 (#s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12) of 17 sampled residents. This failure continued over several months. Findings include: Review of a facility reported incident, dated 9/23/25, reflected that staff member R had more than 50 medication errors involving residents #s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12. For the residents involved, staff member R had either failed to administer medications, complete glucose checks properly, and or failed to complete skin checks. The report showed staff member R had been unavailable for interview(s) as of the completion of the report. The facility identified in the report that no harm was found for the residents affected by the physician's orders not being followed by staff member R. During an interview on 11/17/25 at 11:47 a.m., staff member I stated staff member R seemed fine the day the errors occurred and did not see a reason for the errors to have occurred. Staff member I said she had reported to staff members D and E, that over the last three to four months staff member R seemed to be confused, was asking odd questions that she would normally know (as a long term RN at the facility), she had slurred and slowed speech, was calling people by the wrong names, and on several occasions her eyes were barely open. Staff member I stated staff member R had been showing these changes in the way she acted over the past year, but she had worsened over the past three to four months.During an interview on 11/17/25 at 11:50 a.m., staff member J stated she had reported concerns about staff member R to staff member D approximately three months ago, but did not know what had happened with staff member R related to the reported concerns after that. Staff member J stated other staff were discussing the changes that had been occurring with staff member R, which included a significant weight loss, she had confusion, slurred speech, a slower gait (walking), and wandering at times.During an interview on 11/17/25 at 12:10 p.m., staff member D stated she had received concerns from staff about staff member R's cognitive status and changes and had gone to check on staff member R. Staff member D stated she asked staff member R how she was doing, and staff member R would say she was fine. Staff member D stated she had watched staff member R for a few minutes, and she seemed fine, so she did not investigate the concerns further. Staff member D stated she did not document the concerns reported by staff about staff member R, unless she herself identified concerns. Staff member D stated she had concerns one day when staff member R was found in the lounge, and it had taken several minutes to arouse the staff member. Staff member D stated staff member R had reported she had back pain, so she thought perhaps staff member R was using pain medications, based on her cognitive changes and weight loss. Staff member D stated that one day, staff member R had a resident on the memory unit who was yelling out, and staff member R was . just staring at her cart. Staff member D stated she could hear the resident down the hall behind closed doors yelling, so she went to the unit and assisted the resident while staff member R continued to stare at her cart. Staff member R was also found eating lunch on her medication cart, which was against the facility policy, while surveyors were present in the building. Staff member D stated these were not behaviors/actions she had never seen staff member R display prior. Staff member D stated she did not report these changes or concerns to her supervisor, did not investigate the events that occurred, or document the incidents.During an interview on 11/17/25 at 1:00 p.m., staff member E stated staff member R had an incident sometime in April (2025) with medication errors. Staff member R had been found in the lounge and was non-responsive. Staff member E stated staff member R finally roused and ate something, and she appeared to improve afterwards. Staff member E stated the incidents, which included more than 50 medication errors, were investigated by staff member B. Staff member E stated she was directed to review resident charts, medications, treatments, and blood glucose machines. Staff member E stated the blood glucose machines, which were to be used by staff member R, showed no glucose checks had been completed during staff member R's shift. There was also no charting completed on any residents during staff member R's shift, and it was identified that the medications and treatments had not been completed for 11 residents, which included #s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12 residents. Staff member E stated she checked in with staff member R on occasion because she was concerned about her weight loss and changes in her cognition. Staff member E stated she received concerns from the licensed nursing staff regarding staff member R, which included the possibility that staff member R had an early onset of dementia and the weight loss, but staff member R seemed okay when she

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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, a staff member failed to provide necessary ADL care for a dependent resident when the staff member was directed to provide the necessary care, but the staff member left the shift and did not help the resident, and the resident was found with a soiled brief/chair, for 1 (#6) of 17 sampled residents. Findings include: Review of a facility reported incident, dated 11/4/25, reflected staff member G was instructed to change the brief of resident #6. During the staff's change of shift, resident #6 was found with dried feces up his back and in and under his wheelchair cushion. The facility reported the performance concerns as neglect of care. It was identified this was not a resident care system issue but isolated to the resident. Review of a staff member's witness statement, dated 11/4/25, reflected that the nurse had instructed staff member G to change resident #6's brief because the resident was soiled. When the second shift arrived, resident #6 had dried feces up his back, on his clothing, in his wheelchair, and under his wheelchair cushion. During an interview on 11/17/25 at 2:15 p.m., staff member U stated on the day resident #6 was found covered in feces, staff member U was working. Staff member U stated that staff member G did not change resident #6 when the nurse told her to. Staff member U stated that staff in the area could smell that resident #6 had soiled himself, and stated that staff member G had supposedly gone to change #6's soiled brief, but had returned in under five minutes. Staff member U stated resident #6 required full assistance to be ambulated and for his brief to be changed, and this could not have been done in five minutes or less.This surveyor attempted to contact staff member G, who was on administrative leave, on 11/17/25 at 7:35 a.m. and again at 10:40 a.m. There was no option to leave a message with staff member G, as the phone's voicemail option had not been set up to accept messages. During an interview on 11/17/25 at 1:15 p.m., staff member A stated the Human Resources department, and herself had also reached out to staff member G and received no response. Staff member A stated staff member G was supposed to be available between the hours of 8:00 a.m. and 5:00 p.m. Staff member A stated staff member G had been placed on administrative leave for the third time related to performance issues since September (2025). Staff member A stated some staff complained staff member G was lazy and did not complete her duties. Review of a facility policy, Activities of Daily Living, revised 3/20/25, reflected: .Care and services will be provided for the following activities of daily living per the CNA training Manual to include: . 3. Toileting .Review of a facility policy, Abuse, Misappropriations, and/or Neglect of Residents, revised 11/18/24, reflected: .12. Neglect is the failure of the facility, its employees, or service provider to provide goods and services to a resident necessary to avoid physical harm, pain mental anguish or emotional distress.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interviews, and record reviews, the facility failed to have an effective and accurate system in place for the identification and correction of medication administration documentation omissions for physician-ordered medications. Due to this, it was unknown if the sampled residents received the physician-ordered medications, due to the lack of documentation, or what the reasoning was for the undocumented medication administrations, and it was unknown if a medication error occurred or if the residents had an outcome from an error, since the concerns were unaddressed. Per the facility policy, these medication documentation omissions should have been identified and addressed by the facility staff as medication errors, but were not, and the ongoing concerns were not identified or addressed by the contracted pharmacy in an attempt to correct the concerns, for 14 (#s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14, 16, and 17) of 17 sampled residents. Findings include: 1. Review of a facility reported incident, dated 9/23/25, reflected that staff member R had more than 50 medication errors involving residents #s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12. The facility reported staff member R failed to administer medications, complete glucose checks properly, when insulin was given on a sliding scale, and failed to complete skin checks. The document showed staff member R was unavailable for interview as of the completion of the report. The facility reported incident showed the facility did not identify harm to the residents. This Surveyor attempted to contact staff member R on 11/18/25 at 11:10 a.m., and no response was received. The staff member was on leave. 2. Review of resident #1's medication records, dated 10/1/25 - 11/18/25, reflected that resident #1 had ten missed medication administrations, including the medications olanzapine, budes-formoterol, melatonin, triamcin, senna plus, carbidopa-levodopa, mirtazapine, and quetiapine. There was no documentation on the medication records or nursing notes to reflect why the medications were not administered to resident #1. The medical record did not address the medication errors and or potential outcomes of errors. 3. Review of resident #2's medication records, dated 10/1/25 - 10/31/25, reflected that resident #2 had two missed medication administrations, including the medications quetiapine and atorvastatin. There was no documentation on the records or nursing notes to reflect why the medications were not administered. The medical record did not address the medication errors and or potential outcomes of errors. 4. Review of resident #3's medication records, dated 10/1/25 - 10/31/25, reflected resident #3 had 25 missed medication administrations, including the medications fluticasone, hydrochlorothiazide, prednisolone, atorvastatin, lisinopril, cetirizine, aspirin, latanoprost, amlodipine, quetiapine, and lamotrigine. There was no documentation on the back of the medication record or nursing notes to reflect why the medications were not administered. The medical record did not address the medication errors and or potential outcomes of errors. 5. Review of resident #4's medication chart, dated 10/1/25-10/31/25, reflected resident #4 had missed four medication administrations, including Boost, tamsulosin, and amlodipine. There was no documentation on the back of the medication chart or in nursing notes to reflect why the medications were not administered. The medical record did not address the medication errors and or potential outcomes of errors. 6. Review of resident #5's medication record, dated 10/1/25 -1 1/18/25, reflected that resident #5 had one medication administration, and the record showed 59 fentanyl patch checks were not documented. There was no documentation on the back of the medication record or nursing notes to reflect why the medications were not administered or the patch checks were not completed. The medical record did not address the medication errors and or fentanyl patch checks. 7. Review of resident #7's medication record, dated 9/1/25 - 11/18/25, reflected that resident #7 had 48 missed medication administrations, including senna plus, a very high-calorie drink, risperidone, acetaminophen, divalproex, and olanzapine. There was no documentation on the back of the medication record or in the nursing notes to reflect why the medications were not administered. The medical record did not address the medication errors and or potential outcomes of errors. 8. Review of resident #8's medication record, dated 10/1/25 - 10/31/25, reflected that resident #8 had eight missed medication administrations, including the medications for a multivitamin, metformin, lamotrigine, famotidine, and clonazepam. There was no documentation on the back of the medication record or in the nursing notes to reflect why the medications were not administered. The medical record did not address the medication errors and or potential outcomes of errors. 9. Review of resident #9's medication record, dated 9/1/25 -1 0/31/25, reflected resident #9 had 11 missed medication administrations, including the medications olanzapine, calcium, clonazepam, and acetaminophen; and there were 17 lidocaine patch removals not documented. There was no documentation on the back of the medication record or nursing notes to reflect

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record reviews, facility administrative staff failed to act timely and thoroughly to address concerns brought forth related to a staff member providing resident care and services, and to ensure neglect of care was not occurring, for 11 (1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12); and administrative staff did not identify or act on concerns related to the medication administration policy, procedures, or system, and implement corrections, so concerns were ongoing, and this affected 12 (#s 1, 2, 3, 4, 5, 7, 8, 9, 11, 14, 16, 17) of 17 sampled residents. Findings include:1. Review of a facility reported incident, dated 9/23/25, reflected staff member R had more than 50 medication errors involving residents #s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12. The staff member involved had failed to administer medications, complete glucose checks properly, and failed to complete skin checks. The document showed it was identified there was no harm found for the residents involved. During an interview on 11/17/25 at 11:47 a.m., staff member I stated she had reported concerns to staff members D and E, that staff member R seemed to be confused, had slurred speech, and was calling people by the wrong name. Staff member I stated this had been going on for three to four months; therefore, staff member I reported the concerns to the administrative staff to address. During an interview on 11/17/25 at 11:50 a.m., staff member J stated she had reported concerns several months prior to staff member D, concerns related to staff member R when she was working and providing resident care and services. She stated she was unsure if the concerns she reported were addressed, although an extended period of time had passed. She stated some staff noticed changes with staff member R, such as she had an obvious weight loss, displayed confusion and wandering, had slurred speech, and was walking more slowly.During an interview on 11/17/25 at 12:10 p.m., staff member D stated she had received concerns from facility staff about staff member R's cognitive status. Staff member D stated she checked on staff member R, and she said she was fine. Staff member D stated she watched staff member R for a few minutes, she seemed fine, so she did not investigate further. Although the concerns had been ongoing, staff member D stated she did not document the concerns reported about staff member R. Staff member D stated she thought maybe staff member R was using pain medications which may have affected her weight and cognition. Staff member D stated staff member R did not address a resident's concern when a resident was yelling out, and she had not been following the facility policies, which was not typical for staff member R. Staff member D stated she did not report these concerns to her supervisor, investigate the incidents, or document the incidents related to the licensed staff member and the concerns she was aware of, to ensure resident safety. During an interview on 11/17/25 at 1:00 p.m., staff member E stated staff member R had an incident sometime in April 2025 with medication errors. Staff member R was found in the lounge and was non-responsive, but seemed to improve after. Staff member E stated the situation with the more than 50 medication errors was investigated by staff member B. Staff member E stated she was directed to review resident charts, medications, treatments, and blood glucose machines, and identified concerns with 11 (#s 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12) residents. Staff member E stated she did receive concerns regarding staff member R, and stated she did not report the concerns to a supervisor, investigate the concerns, or document the concerns presented by the nursing staff, to ensure resident safety. During an interview on 11/17/25 at 2:13 p.m., staff member L stated she had reported concerns to administrative staff about staff member R, when she identified concerns related to staff member R's work duties and actions, after she worked the shifts following after staff member R. The concerns included medications being found in different drawers, medications not being given, and the staff member's cognition changes. Staff member L stated that staff member R had been having cognitive issues for three or four months, and then she went on a leave of absence. Staff member L stated she reported the missed medication administrations to staff member I. During an interview on 11/17/25 at 2:30 p.m., staff member A stated the care staff member R provided was good, and the medication error rate had improved. She stated she could not investigate someone (a staff member) for cognitive issues because they were personal issues. Staff member A stated the concerns of staff member R's changes, such as the slurred speech, cognitive changes, and dementia, had not been reported to her by the supervisors. 2. During an observation and interview on 11/18/25 at 9:48 a.m., staff member I stated she reviewed the medications listed on the resident medication records to ensure accuracy. Staff member I stated she was not sure who reviewed the medication records for missed doses or holes in the chart. Staff member I stated she submitted a medication error report to the QAPI team monthly, but the missed doses were only considered when the medication was