STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275047	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Health & Rehabilitation Center	510 S 14th St Livingston, MT 59047

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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 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 interview and record review, licensed nursing staff neglected to provide the necessary services to a resident and assess for and treat pain and anxiety, for 1 (#116) of 2 residents sampled for pain management, and the nurse stated the resident was restless, a symptom of both anxiety and pain. The neglect of care negatively affected the resident's comfort. Findings include:During an interview on 10/21/25 at 10:30 a.m., staff member B reported she investigated a facility-reported incident involving neglect of care on multiple residents. Staff member B reported she was concerned one resident had not received adequate pain and anxiety management from the nurse on duty on the 12-hour night shift between 6:00 p.m. on 9/25/25 and 6:00 a.m. on 9/26/25. Staff member B stated resident #116 was a hospice resident, and the resident was in end-of-life transition. The resident had been receiving as-needed lorazepam for anxiety, twice daily, and morphine several times per shift, due to restlessness and agitation. Staff member B stated on the 12-hour night shift between 6:00 p.m. on 9/25/25 and 6:00 a.m. on 9/26/25, NF4 gave resident #116 one dose of morphine for pain at 5:59 a.m., and no lorazepam for anxiety. Staff member B stated she was able to confirm the one dose of pain medication was given by reviewing the resident's narcotic log and narcotic count.During an interview on 10/20/25 at 3:35 p.m., NF4 stated, . I gave that guy (resident #116) his morphine all night except for one dose when I couldn't get it into him because he was restless. The staff member was inconsistent in her accounting of the events and did not seem to recognize the restlessness could have been pain/anxiety related. Review of the facility's investigation documentation for the Facility-Reported Incident, dated 9/26/25, showed the following undated statement obtained from NF4 via phone: I kept up on all medication administration, even with (residents #9 and #116) being out of sorts, and combative .Review of resident #116's MAR for September 2025, showed that on 9/25/25, resident #116 received morphine at 12:56 a.m., 5:56 a.m., 9:51 a.m., and 12:59 p.m. The next dose was administered on 9/26/25 at 5:59 a.m., and it was 17 hours since the previous dose, which was the only dose given to the resident on NF4's shift.Review of resident #116's nursing progress notes, for September 2025, did not show any nursing entries for the period of 6:00 p.m. on 9/25/25 through 6:00 a.m. on 9/26/25, and why pain or anxiety medications were neglected to be given, or if the resident was assessed for why he was restless and or out of sorts.

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 0609 Level of Harm - Potential for minimal harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, facility staff failed to report investigative findings for reportable events, within the required timeframe, for 2 (#s 16 and 123) of 2 residents sampled for injuries. Findings include:1. Review of a facility-reported incident, submitted to the State Survey Agency on 8/28/25, showed resident #16 sustained a hematoma of unknown origin to the left lower extremity. The facility's investigative findings were not reported to the State Survey Agency until 9/9/25; two days after the submission deadline.During an interview on 11/18/25 at 10:42 a.m., staff member A stated he was responsible for submitting the facility's reportable incidents through the incident reporting system. Staff member A stated he accidentally pressed the save button instead of the send button in the reporting system and did not realize it until two days past the deadline.2. Review of a facility-reported incident, submitted to the State Survey Agency on 9/16/25, showed resident #123 sustained swelling and bruising of unknown origin to the right hand. The facility's investigative findings were not reported to the State Survey Agency until 9/25/25; two days after the submission deadline.During an interview on 11/18/25 at 10:42 a.m., staff member A stated he did not think the incident should have been reported, but the facility did report it as an unknown injury. Staff member A did not feel that the late reporting of the incident should be considered deficient practice. As with the incident above, staff member A stated he pressed the save button instead of the send button in the reporting system and did not realize it until two days past the deadline.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility staff failed to complete a thorough investigation and comprehensive corrective action, following a facility-reported event involving neglect allegations related to bowel and bladder care of 5 dependent residents (#s 12, 32, 33, 42 and 112); and staff failed to document physician ordered medication and treatment orders for 23 residents (#s 6, 9,12, 13, 15, 20, 22, 23, 27, 32, 33, 112, 114, 116, 118, 121, 123, 124, 126, 127, 131, 133, and 199) of 24 sampled residents. Findings Include: Review of a Facility-Reported Incident, submitted to the State Survey Agency on 9/26/25, included two separate incidents involving neglect of resident care. The first event occurred on the 12-hour night shift beginning at 6:00 p.m. on 9/19/25. NF3 was working the night shift and was reported by other staff to be missing for extended periods of time with another staff member. Day shift staff reported resident #12, 32, 33, 42, and 112, who were all assigned to NF3's care, were found during the morning rounds heavily saturated in urine and feces. The second event occurred on the 12-hour night shift, beginning at 6:00 p.m. on 9/25/25. On the morning of 9/26/25, resident #20 reported neither she nor her roommate received their morning medication from the night nurse. Resident #20's statement prompted a facility investigation, which revealed NF4 failed to document medications and treatments given for resident #s 6, 9, 12, 13, 15, 20, 22, 23, 27, 32, 33, 112, 114, 116, 118, 121, 123, 124, 126, 127, 131, 133, and 199 during her shift. The facility's investigation and report of findings, dated 10/2/25, included the following corrective actions: Staff were educated on reporting and recognizing abuse and neglect by the Administrator on 10-1-25 and 10-2-25 . DNS will report the licensed nurse (NF4) to the Montana Board of Nursing by 10/3/25 . All licensed staff will be in-serviced by the Director of Nursing Services on med administration and documentation compl . [sic]During an interview on 10/20/25 at 1:11 p.m., staff member J stated she believed she had abuse training through her contract agency and recently had received an abuse policy to review and sign for the facility, but there wasn't really any training with it. Staff member J stated she had not received medication administration and documentation training at the facility within the past two months, as noted to be done in the facility investigation notes. During an interview on 10/20/25 at 1:15 p.m., staff member F stated she had received abuse training review recently, but it did not apply to this neglect issue (being investigated) really. Staff member F stated she did not recall any medication-related training in the past two months. During an interview on 10/20/25 at 1:34 p.m., staff member G stated there was sexual abuse training recently, but staff member G did not recall any training on the identification and reporting of resident neglect. Staff member G stated the education consisted of a review of the abuse policy, sign-off on receipt of the policy, and a short quiz with sexual abuse scenarios. During an interview on 10/20/25 at 1:52 p.m., staff member I stated she could not recall if she had abuse and neglect training recently.During an interview on 10/21/25 at 10:38 a.m., staff member B stated the facility became aware of both incidents on 9/26/25 with NF4. Staff member B reported the incident to staff member A and began investigating the allegations. Staff member B stated her investigation involved pulling medication administration records and the bowel and bladder task reports for all affected residents, interviewing residents, and interviewing staff. During her investigation, staff member B stated she identified 21 residents were negatively affected, and their medication and treatment administration records were left incomplete by NF4 between 9/25/25 at 6:00 p.m. and 9/26/25 at 6:00 a.m., which showed the treatments and medications were not provided. Staff member B stated she reviewed the controlled substance logs for the residents who were prescribed controlled substances to ensure there were no discrepancies in the medication count, but did not confirm the same with the other medications using the facility's blister pack system for medication administration. Staff member B stated, I just never thought to do that. During an interview on 10/21/25 at 1:50 p.m., staff member B stated there was an informal interdisciplinary meeting held on 10/1/25, wherein department heads received updated abuse and neglect training, but it was not a formal QAPI meeting.During an interview on 10/21/25 at 2:12 p.m., staff member C stated there had been no QAPI meeting following the incident on 9/26/25, to identify quality-deficient practices and or needed corrections related to the events and NF4.During an interview on 10/21/25 at 3:40 p.m., staff member A stated he held a focused (adhoc) QAPI meeting after the reportable incident, as part of the facility's plan for correction. Staff member A provided a QAPI committee minutes form with three names listed: the administrator, a corporate regional nurse, and corporate regional administrator. Staff member A stated, Everyone was there, I just haven't gathered the rest of the signatures yet. The report was dated 10/1/25. Staff member A stated the staff had all received refresher training on abuse and neglect. When the

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update a care plan to reflect a resident's ability to transfer from a wheelchair to a bed. The failure increased the resident's risk of injury during transfer for 1 (#16) of 2 residents sampled for injuries. Findings include:Review of a facility-reported incident, submitted to the State Survey Agency on 8/28/25, showed resident #16 sustained a hematoma of unknown origin to the left lower extremity. The facility's investigation determined the injury likely occurred as a result of a difficult resident transfer from a wheelchair to a bed.During an interview on 11/17/25 2:02 p.m., staff member L stated a resident's ability to transfer and any devices required would be found in the resident's care plan. During an interview on 11/18/25 at 2:57 p.m., staff member B stated, Care plans are updated by myself, the MDS nurse, or the charge nurse . When we receive new orders from PT, it goes to a binder at the nurses station, and we update the care plan at that time . Staff member B stated resident #16's care plan had not been updated to reflect her current transfer status and ability. Staff member B did not know why the care plan was not updated.Review of resident #16's physical therapy progress notes dated 7/23/25, showed, . Progress Report completed with review patient's performance and progression toward goals; removed standing and transfer goals as patient has too much pain and does not want to work on that anymore; Continued PT services are necessary to improve w/c mobility [sic]Review of resident #16's care plan, initiated 5/22/25, showed, The resident is able to perform all transfers with assist of one. No additional updates on resident #16's transfer status or ability were located in the care plan after 5/22/25.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, a facility nurse failed to ensure nursing services were provided in accordance with professional standards for medication administration and documentation for 23 (#s 6, 9, 12, 13, 15, 20, 22, 23, 27, 32, 33, 112, 114, 116, 118, 121, 123, 124, 126, 127, 131, 133, and 199) residents, of 24 sampled, and the residents medical records did not reflect if the residents received their ordered medications. Findings include:During an interview on 10/20/25 at 3:35 p.m., NF4 stated, . I did everything I was supposed to that night (the night shift between 9/25/25-9/26/25) . and I told the oncoming nurse I was planning to late entry my notes. they reported me to the Board of Nursing . they (facility) hated me. some of the problem was that (the electronic medical record system) was not saving my (entries) . I gave that guy his morphine all night except for one dose, when I couldn't get it into him, because he was restless .During an interview on 10/20/25 at 3:10 p.m., resident #20 stated, . I didn't get my thyroid med that day (9/26/25) and neither did my roommate, although she won't remember. Resident #20 stated she filed a grievance on the concern.During an interview on 10/21/25 at 10:16 a.m., staff member K stated, Residents complain about (NF4) a lot for late meds or no meds. One day recently, a resident told (NF4) that he didn't get his med, and (NF4) told him she was 80% sure she gave it to him already. Staff member K went on to say, 80%, I thought that was weird, referring to NF4 not absolutely knowing if the medication was given. Staff member K stated there was another incident where a resident told the staff member he didn't get his medications, and staff member K stated he told NF4 about it. Staff member K stated he did not want to identify the residents (who didn't get the medications or voiced complaints to him) as he didn't want to get anyone in trouble.During an interview on 10/21/25 at 10:38 a.m., staff member B stated she investigated the events involving NF4 on the night shift ending on 9/26/25, after resident #20 reported she and her roommate (resident #13) had not received their morning thyroid medicine on 9/26/25. Staff member B stated the investigation revealed NF4 had not completed the medication and treatment records for 21 residents during her 12-hour shift, which started at 6:00 p.m. on 9/25/25, and the shift ended at 6:00 a.m. on 9/26/25. Staff member B stated the records were highlighted in red in the EMR, reflecting the monitoring, treatments, or medications not performed, administered, or signed off by NF4. Staff member B reported inconsistencies during her interview, which included statements that everyone received their treatments and medications. Later, staff member B reported everyone received their medication, except resident #20, even though resident #20's Medication Administration Record (MAR) showed she was administered the thyroid medication at 5:35 a.m. Resident #13's thyroid medication was administered at 5:51 a.m., per the MAR. Staff member B stated resident #20 has a BIMS score of 15; cognitively intact, and she is very reliable and makes sure everyone (staff) does their work. The resident also looks out for her roommate, who has a BIMS of 5; severe cognitive impairment. Staff member B stated resident #116 was on hospice and only received one dose of morphine sulfate during NF4's 12-hour shift, and the resident was receiving the morphine pain medication approximately every two hours on prior shifts. Staff member B stated NF4 told her resident #116 had been restless all night. Staff member B stated the facility's narcotic log matched the medication does sign out documentation. Staff member B stated NF4 told her she was planning to come back the next shift and complete all the documentation (as late entries in the medical record) because she had a migraine headache.During an interview on 10/21/25 at 1:30 p.m., staff member E stated she had received a report from NF4 on 9/26/25, and she had not mentioned/noted she had a headache. Staff member E stated NF4 did not report that she didn't finish her charting. Staff member E stated, She seemed fine, just in a hurry to go. She tried to tell me that everyone was fine, and I had to make her go over the report . it was a busy day trying to fix all the issues and getting the residents comfortable . Review of resident MARs for the period of 6:00 p.m. on 9/25/25 through 6:00 a.m. on 9/26/25, showed the following concerns were not addressed by NF4:1. Resident #6: Catheter care, psychotropic side effect monitoring, serotonin syndrome monitoring, Enhanced Barrier Precautions (EBP) monitoring, shortness of breath monitoring, weekly skin evaluation, nighttime left wrist hand splint application, and pain monitoring were not documented as completed.2. Resident #9: The skilled care vital signs every shift, anticoagulation side effect monitoring, shortness of breath monitoring, psychotropic side effect monitoring, oxygen saturation, and the oxygen flow rate were not documented as completed. Dermaseptine ointment to #9's sacrum/coccyx, over blanchable redness, was not documented as administered per the physician's order.3. Resident #12: EBP monitoring, shortness of breath monitoring, pain monitoring, and psychotropic side effect

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure a resident was transferred safely and correctly, and the resident sustained an injury to the left lower extremity with swelling and bruising which the nurse documented as being tennis ball size, and it was identified the injury was caused due to staff manually transferring the resident, which was not the correct transfer status, for 1 (#16) of 2 residents sampled for injury. Findings include: Review of a facility-reported incident, submitted to the State Survey Agency on 8/28/25, showed resident #16 sustained a hematoma of unknown origin to the left lower extremity. The facility's investigation determined the injury likely occurred as a result of a difficult resident transfer from the wheelchair to bed.Review of resident #16's medical record showed on 8/28/2025 at 10:40 a.m., the nurse documented the resident stated there was an accident, and the nurse detailed the assessment of the resident's left lower extremity injury, which was soft tissue swelling just below left knee. Area is the size of a tennis ball .Review of a written statement from staff member Q, dated 8/28/25, showed, Resident was found in her wheelchair with no sling under her and wanted to be transferred to bed. Nurse and [staff member P] attempted to place a sling under her but she was too weak so they had to do a stand pivot transfer with gait belt to get her safely back to bed with 3 staff members present .A verbal request was made on 11/18/25 for the most recent therapy recommendation forms for resident #16. Two forms were received, dated 6/9/25 and 6/20/25. Neither form was related to resident #16's transfer status or ability to transfer.During an interview on 11/17/25 2:02 p.m., staff member L stated, I understand that PT forgot to put a sling underneath her (resident #16), and the CNAs had trouble getting her back to bed with pivot and lift . The CNAs should have been told how to transfer the resident . During an interview on 11/18/25 at 10:40 a.m., staff member B stated resident #16 was supposed to be transferred only using a hoyer lift (full body lift). Staff member B stated the physical therapist had transferred resident #16 earlier in the day from her bed to her wheelchair using a slider board and did not leave a hoyer lift sling underneath her, therefore, the staff had to attempt a stand and pivot transfer with the resident. Staff member B stated resident #16 was very weak, and the transfer was difficult. Staff member B stated physical therapy should have ensured the staff could safely transfer resident #16 back into her bed.During an interview on 11/18/25 at 1:41 p.m., staff member O stated resident #16 had been regressed by nursing staff to hoyer lift transfers due to weakness, and therapy was using a slider board to transfer resident #16. Staff member O stated she believed there was a system problem or communication problem, as the therapists were getting pulled into resident rooms frequently by CNAs to relay a transfer status or instruct staff on transferring residents.Review of resident #16's care plan, dated 5/22/25, showed the resident was able to perform all transfers with one person assisting, and there were no further updates to resident #16's transfer status in the care plan.