STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275029	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yellowstone River Nursing and Rehabilitation	2115 Central Ave Billings, MT 59102

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 14005 Based on record review and interview, the facility failed to ensure PRN (as needed) anti-anxiety medication was limited to 14 days for 1 (#49) of one sampled resident and failed to ensure an adequate indication of use for an antipsychotic for 1 (#99) of 1 sampled resident. Findings include: Review of resident #49's March 2024 Medication Administration Report, showed resident #49 was started on routine Diazepam 2 mg (milligram) oral tablet one time a day for anxiety. In addition, resident #49 could also receive Diazepam 1 mg by mouth every twenty-four hours as needed for six hours after the scheduled dose. This psychotropic medication was ordered approximately every fourteen days for more than eight months. Review of resident #49's Treatment Administration Record dated 10/2024, showed the resident was assessed as a zero or no signs of anxiety during shifts when resident #49 received the as needed dose of diazepam. Review of resident #49's pharmacy drug regimen review dated 8/21/24, showed the pharmacy had identified the resident was receiving, Diazepam 2 mg every day since 3/2024 and had a prn order for diazepam 1 mg once daily as needed on 8/19/24. The pharmacy asked for a review and a gradual dose reduction for the medication. The pharmacy requested supporting documentation showing a gradual dose reduction was contraindicated. The physician failed to show why the reduction was contraindicated. The physician documented use is appropriate for relevant current standards. The physician did not provide any information on the resident behaviors, the residents response to the medication, or the risks or benefits of continuing the psychotropic medication. Review of resident #99's nurses note, dated 10/1/24, showed a physical altercation between resident #49 and #99. Resident #99 was moved to another room on a different unit and moved to a different dining room table away from resident #49. Review of resident #99's MAR (Medication Administration Record) for October 2024, showed resident #99 was getting the antidepressant Sertraline 25 mg by mouth at bedtime for anxiousness. On 10/30/24 resident #99's Sertraline dose was doubled and changed to 50 mg at bedtime daily for anxiousness. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275029	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yellowstone River Nursing and Rehabilitation	2115 Central Ave Billings, MT 59102

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #99's October 2024 TAR (treatment administration record) showed resident #99 did not have any behaviors on 10/1/24 the day resident #99 hit resident #49 several times. The October 2024 TAR showed the resident did not have any increase in behavior. This TAR showed the nurses only monitored for side effects of the medication six times out of 62 possible times. The physician had ordered the nurse to monitor the side effects every shift. The documentation showed the resident suffered from side effects of his anti-anxiety medication 14 times in October, but nothing was done to prevent further side effects. Review of resident #99's nurse's notes, dated 11/4/24, showed resident #99 was physically aggressive and grabbed resident #103. Resident #103 got an abrasion on his hand. Resident #99's POA was contacted and resident #99 was moved into a private room, and after the second altercation, a one-to-one care giver was assigned. Review of resident #99's psychotropic review, dated 10/31/24, showed the sertraline was increased related to ongoing depression and anxiety. Review of #99's nursing notes, documented from 10/3/24 through 11/3/24, did not show any signs or depression, anxiety, or agitation. Review of resident #99's November 2024 MAR showed, Seroquel was started 11/4/24, after resident #99 hit resident #103. The reason for starting an antipsychotic was for sundowning with agitation. Review of physician progress notes dated 11/4/24, showed the physician assistant documented the nurses reported increased agitation and has had other physical altercations with other residents. The assessment plan showed, #Violence against fell ow resident, recurrent episode # Anxiety. The physician assistant ordered the sertraline switched from nighttime to a morning dose and to start Seroquel at this time. During an interview on 12/17/24 at 12:20 p.m., staff member B said the behaviors should be documented on the medication administration record or in the nurse's notes. Staff member B said the responses for documenting behaviors or episodes of anxiety or agitation do not always get documented. Staff member B said education was recently provided on behaviors and this education included documentation. Staff member B said the interdisciplinary team reviews the residents at the care conferences and as needed with changes. Staff member B said the interdisciplinary team did not look for trends to identify the cause of the resident's anxiety or to determine what interventions could be done to reduce the risk of anxiety. Staff member B said the pharmacy tracked the psychotropic medications and made recommendations to the physician. Staff member B said she was unaware the staff could question the physician's orders for psychotropic medication.