

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/27/2025
NAME OF PROVIDER OR SUPPLIER Yellowstone River Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41652</p> <p>Based on observation and interview, the facility failed to provide equal access to quality care for 1 (#7) of 18 sampled residents. The resident was placed in a room without a sink, bathroom, or call light. The resident slept on a mattress placed on the floor. Findings include:</p> <p>During an interview on 3/25/25 at 12:05 p.m., NF3 stated she was at the facility on the morning of 3/5/25. NF3 stated she was unable to locate resident #7 in his assigned room. An unknown staff member directed NF3 to the Country Store, located in the secure memory care unit. NF3 stated she found resident #7 lying on a mattress, on the floor, in the Country Store. NF3 stated the lights were turned off and the door was partially closed. NF3 stated the room looked like a storage room of sorts, with no bathroom or call light seen. NF3 stated the staff on the unit told her resident #7 had been sleeping there for a couple of nights because there was not an empty, available, room on the secure unit. NF3 stated she was told the facility had tried to place resident #7 on a regular unit, rather than the secure memory care unit. NF3 was told resident #7 did not do well and wandered, and he was temporarily placed in the Country Store. NF3 stated she was not sure how long resident #7 was residing in the Country Store.</p> <p>During an interview on 3/26/25 at 10:50 a.m., staff member C stated she was involved in the multiple room changes which occurred when the facility removed four rooms from the secure memory care unit and added the four rooms to a regular unit. Staff member C stated, residents who were in double rooms by themselves, were moved to double rooms with a roommate. Staff member C stated there was an attempt to place resident #7 on a regular unit. However, the resident did not make it and had to be moved back to the secure memory unit.</p> <p>During an interview on 3/27/25 at 8:45 a.m., staff member G stated resident #7 was in the secure memory unit during the day on 3/4/25 and 3/5/25. Staff member G stated resident #7 did not have a bed or room on the unit as they were all occupied. Staff member G stated on 3/4/25 they (staff on duty) placed the resident on the couch, in the television room. Staff member G stated the resident did not sleep because the area was too bright and noisy for him. Staff member G stated, on 3/4/25, a message from facility management was relayed to her by the day staff to figure it out and the room situation would be resolved in the morning (3/5/25). Staff member G stated she knew there was no call light or bathroom in the Country Store. Staff member G stated they kept a close eye on #7 and walked resident #7 to the toilet, in the shower room, at the other end of the secure memory unit.</p> <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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/27/25 at 9:07 a.m., staff member B was aware resident #7 was not safe out of the secure unit due to wandering. Staff member B stated she thought the resident slept on the couch or recliner in the television room until a bed could be freed up for resident #7. Staff member B stated she was not aware resident #7 slept at least one night on a mattress, on the floor, in the Country Store.</p> <p>During an interview on 3/27/25 at 9:55 a.m., staff member A stated he was aware of the attempt to place resident #7 on a regular unit, rather than the secure memory unit. Staff member A stated he was not aware resident #7 spent at least one night on a mattress, on the floor, in the Country Store.</p> <p>During an observation on 3/27/25 at 11:15 a.m., the Country Store was observed to be two open areas measuring approximately 13 feet by seven and one-half feet and nine and one-half feet by eight feet. The entry door was adjacent to the hallway. The area contained two locked storage areas, and a clear glass set of double doors which led to an interior courtyard. The area did not contain a sink, a bathroom, a private closet, or a call light.</p>

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<p>F 0559</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 share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652</p> <p>Based on interview and record review, the facility failed to provide written notice for a room change, including the reason for the change, for 2 (#s 7 and 8) of 3 residents sampled for room changes. Findings include:</p> <p>1. Review of resident #7's Census tab in the EHR, viewed on 3/24/25, showed the following room changes for the resident:</p> <ul style="list-style-type: none"> - 2/25/25, moved from room [ROOM NUMBER] to room [ROOM NUMBER], - 3/5/25, moved from room [ROOM NUMBER] to room [ROOM NUMBER]; and, - 3/12/25, moved from room [ROOM NUMBER] to room [ROOM NUMBER]. <p>Review of resident #7's Assessment tab, viewed on 3/24/25, failed to show a Notification of Room/Roommate Change forms for the 3/5/25 and 3/12/25 room changes.</p> <p>Review of resident #7's Progress Notes tab, viewed on 3/25/25, failed to show any of the room or unit changes which occurred on 2/25/25, 3/5/25, and 3/12/25.</p> <p>During an interview on 3/25/25 at 8:50 a.m., NF1 stated he had been made aware of the room change from the secure memory unit to a regular unit. NF1 stated he was not notified, either verbally or in writing, of the resident's move back into the secure unit on 3/5/25 or the room change on 3/12/25. NF1 stated he thought the resident was still in a regular room.</p> <p>2. Review of resident #8's Census tab in the EHR, viewed on 3/25/25, showed the resident was moved from room [ROOM NUMBER] to room [ROOM NUMBER] on 3/4/25.</p> <p>Review of resident #8's Assessment tab, viewed on 3/25/25, failed to show a Notification of Room/Roommate Change form for the 3/4/25 move from room [ROOM NUMBER] to room [ROOM NUMBER].</p> <p>Review of resident #8's Progress Notes tab, viewed on 3/25/25, failed to show the resident's room change or the reason for the move.</p> <p>During an interview on 3/25/25 at 10:21 a.m., NF4 stated she was not notified of the room change or the reason for the room move which took place on 3/4/25. NF4 stated she did not find out about the room change until she recently visited and could not find the resident in room [ROOM NUMBER].</p> <p>Review of the facility's policy titled, Room Change/Roommate Assignment, last revised March of 2021, showed, . 4. Prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., residents and their representatives) are given advance written notice of such change . includes why the change is being made .</p>		

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<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>41652</p> <p>Based on interview and record review, the facility failed to notify a resident's representative when a change in condition necessitating a transfer to a higher level of care for 1 (#1) of 4 residents sampled for appropriate transfer. Findings Include:</p> <p>During an interview on 3/25/25 at 11:05 a.m., NF5 stated she was not notified when resident #1 was admitted to an acute care hospital on 2/16/25. NF5 stated she was notified when resident #1 attempted to elope and became very agitated. But was not notified when the decision was made to transfer resident #1 to the hospital for a psychiatric evaluation. NF5 stated she did not know about the transfer or the admission until another family member arrived at the facility to visit and was told he was in the hospital.</p> <p>Review of resident #1's documents received from the acute care hospital, dated between 2/16/25 and 2/24/25, showed the following:</p> <ul style="list-style-type: none"> - 2/16/25, History and Physical, increased confusion and agitation, unclear etiology, - 2/17/25, Hospital Progress Note, worsening confusion secondary to steroids, baseline dementia, and dehydration made worse by Lasix, - 2/18/25, Behavioral Health Note, gradual improvement; and, - 2/22/25, Hospital Progress Note, medication adjustments, continued improvement. <p>Review of resident #1's Entry Tracking Record, dated 2/24/25, showed the resident was admitted to the facility from an acute care hospital on 2/24/25.</p> <p>Review of resident #1's Progress Notes, dated from 2/16/25 through 2/24/25, failed to show the resident's representative was notified of the resident's change in condition and transfer to the acute care hospital for care.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>51133</p> <p>Based on interview and record review the facility failed to ensure meals were served at an appetizing temperature to ensure resident satisfaction for 4 (#s 15, 16, 17 and 18) of 4 sampled residents for food satisfaction. Findings include:</p> <p>During an interview on 3/26/25 at 3:58 p.m., resident #18 stated when meals are served, they are not hot.</p> <p>During an interview on 3/27/25 at 8:33 a.m., staff member I stated she receives complaints from residents that room trays are cold all the time.</p> <p>During an interview on 3/27/25 at 8:47 a.m., resident #15 had just received her breakfast tray and reported her food was cold.</p> <p>During an interview on 3/27/25 at 12:51 p.m., resident #16 had just received her lunch meal in her room and stated she was disappointed because her food was not warm.</p> <p>During an interview on 3/27/25 at 1:25 p.m., resident #17 stated the food which is delivered to resident rooms is mostly cold. Resident #17 reported she often eats yogurt at lunch and more often than not, her yogurt is served warm, and she prefers yogurt to be served cold.</p> <p>A review of resident council minutes showed the following:</p> <ul style="list-style-type: none"> - November Resident Council, dated 11/6/24, showed, . Dietary: Food seems to be cold even in in the dining room . - December Resident Council, dated 12/4/25, showed, . Dietary: Food is cold . - January Resident Council, dated 1/8/25, showed, .Dietary: Food is cold . - March Resident Council, dated 3/5/25, showed, . Dietary: Food is cold . 		

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<p>F 0918</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide a bathroom in or located near each resident's room.</p> <p>41652</p> <p>Based on observation and interview, the facility failed to ensure each resident room was equipped with a sink and toilet for 1 (#7) of 18 sampled residents. Findings include:</p> <p>During an interview on 3/25/25 at 12:05 p.m., NF3 stated she was at the facility on the morning of 3/5/25. NF3 stated she was unable to locate resident #7 in his assigned room. An unknown staff member directed NF3 to the Country Store. located in the secure memory care unit. NF3 stated the room looked like a storage room of sorts, with no sink or bathroom seen. NF3 was told the resident was placed in the Country Store temporarily, and she was not sure how long resident #7 was in the Country Store.</p> <p>During an interview on 3/27/25 at 8:45 a.m., staff member G stated resident #7 did not have a bed or room on the secure unit as they were all occupied. Staff member G stated, on 3/4/25, a message from facility management was relayed to her by the day staff to figure it out and the room situation would be resolved in the morning (3/5/25). Staff member G stated she knew there was no sink or bathroom in the Country Store. Staff member G stated they kept a close eye on the resident and walked resident #7 to the toilet, in the shower room, at the other end of the secure memory unit.</p> <p>During an observation on 3/27/25 at 11:15 a.m., the Country Store was observed to be two open areas measuring approximately 13 feet by seven and one-half feet and nine and one-half feet by eight feet. The entry door was adjacent to the hallway. The area contained two locked storage areas, and a clear glass set of double doors which led to an interior courtyard. The area did not contain a sink or a toilet.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>41652</p> <p>Based on observation and interview, the facility failed to ensure each resident's sleeping area had functioning call light for 1 (#7) of 18 sampled residents. Findings include:</p> <p>During an interview on 3/25/25 at 12:05 p.m., NF3 stated she was at the facility on the morning of 3/5/25 and was unable to locate resident #7 in his assigned room. An unknown staff member directed NF3 to the Country Store. located in the secure memory care unit. NF3 stated the Country Store looked like a storage room of sorts. NF3 stated she noted there was no call light for the resident, who was lying on a mattress on the floor.</p> <p>During an interview on 3/27/25 at 8:45 a.m., staff member G stated resident #7 was in the secure memory unit during the day on 3/4/25 and 3/5/25. Staff member G stated resident #7 did not have a bed or room on the unit as they were all occupied. Staff member G stated, on 3/4/25, a message from facility management was relayed to her by the day staff to figure it out and the room situation would be resolved in the morning (3/5/25). Staff member G stated she knew there was no call light in the Country Store, but had no other options.</p> <p>During an interview on 3/27/25 at 9:07 a.m., staff member B stated resident #7 slept at least one night on a mattress, on the floor, in the Country Store, where there was no call light.</p> <p>During an interview on 3/27/25 at 9:55 a.m., staff member A stated he was not aware resident #7 spent at least one night in the Country Store, where there was no call light.</p> <p>During an observation on 3/27/25 at 11:15 a.m., the Country Store was observed to and the room did not contain a call light.</p>