| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275029 | A. Building<br>B. Wing | 06/05/2025 |

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

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on interview and record review, the facility failed to complete a thorough investigation involving a resident who had access to, and went out of, a door which was not alarmed with a wander guard alarm system. The resident left the facility property, accessing a public road, traveling 0.2 miles on foot without staff supervision. The facility failed to identify exit doors not equipped with a wander guard alarm system which would alert staff to redirect a resident prior to exiting an emergency egress door as a hazard for 1 (#1) of 9 sampled residents for wandering and elopement risk. The facility's failure to address these concerns placed this resident, and any others at risk of eloping, at continued risk of imminent harm. Findings include:<br><br>A Facility Reported Incident, dated 3/28/25, was submitted to the State Survey Agency for an incident involving resident #1 who eloped from the facility. Review of the facility's report of findings, dated 4/2/25, included the following information:<br><br>Resident #1 eloped from the facility on 3/28/25 at 7:30 p.m. Facility staff identified an emergency egress door at the end of the hall on the crossroads unit had alarmed. When staff responded to the alarm and searched the area no residents were seen outside. Local law enforcement was contacted, and the resident was found and brought back to the facility by police on 3/28/25 at 7:57 p.m. The report showed resident #1 would remain on the secured unit during daytime hours until a secure bed became available. Resident #1 would have 1:1 supervision during the night, and social services would continue to monitor resident #1's psychosocial well-being. The facility failed to address the first set of exit doors resident #1 opened which were not equipped with a wander guard alarm system. This allowed resident #1 to exit the second set of doors which were emergency egress doors at the end of the hall on the crossroads unit.<br><br>(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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/2/25 at 4:21 p.m., staff member C stated resident #1 was reviewed by the IDT after his elopement from the facility on 3/28/25. Staff member C stated a progress note summary of the IDT meeting should have been entered into the resident's medical record, and she was not sure why it was not in the EHR system. Staff member C stated resident #1 continued to use a wander guard device, and he was on 1:1 staff monitoring, until he was transferred to the facility's secure unit on 4/7/25. Staff member C stated the doors in the facility which were not alarmed with a wander guard system, including the doors on the sapphire and crossroads unit, and were not identified by the IDT as the root cause of resident #1's elopement, although the resident had left through the first set of exit doors at the end of the hall on the crossroads unit. Staff member C stated the wander guard alarm system was not needed on the first set of exit doors at the end of the hall on the sapphire and crossroads units because the second set of doors on both units were equipped with an alarm on the second set of doors, which were emergency egress doors and would alarm when a resident exited. Staff member C stated the doors Staff member C stated she would be most concerned with residents who were an elopement risk exiting the facility and getting hit by a car. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on interview and record review, the facility failed to update a resident care plan with a new fall intervention identified by the IDT, for 1 (#7) of 9 sampled residents. The failure placed the resident at risk for recurrent falls and injuries. Findings include:<br><br>Review of resident #7's nursing progress note, dated 5/31/25, showed the resident had an unwitnessed fall. The progress note showed resident #7 was sitting in a chair in the dining room. Resident #7 attempted to scoot forward in the chair, but she slid out, landing on her buttocks.<br><br>Review of resident #7's current care plan, undated, failed to show a new fall intervention to address why or how the resident slid from her wheelchair, for the resident's fall on 5/31/25, as identified by the IDT.<br><br>A review of resident #7's IDT event review note, dated 6/4/25, showed, New Interventions suggested following current IDT review: Intervention is redirect resident to the couch to sit in instead of the chairs as she is able to get up off the couch without any difficulty, care plan reviewed and updated. [sic] The intervention identified by the IDT for the resident's fall was not documented on the resident's care plan. Therefore, direct care staff did not have access to the intervention to ensure the resident's safety related to falls.<br><br>During an interview on 6/5/25 at 2:25 p.m., staff member B stated resident #7's fall on 5/31/25 was reviewed by IDT. Staff member B stated the new intervention for resident #7 should have been updated on the resident's plan of care, and she did not know why it was not on the care plan.<br><br>Review of the facility document titled, Care Plans, Comprehensive Person Centered, undated, showed:<br><br>Policy Interpretation and Implementation<br><br>.13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.<br><br>14. The Interdisciplinary Team must review and update the care plan:<br><br>a. When there has been a significant change in the resident's condition;<br><br>b. When the desired outcome is not met;<br><br>c. When the resident has been readmitted to the facility from a hospital stay; and<br><br>d. At least quarterly, in conjunction with the required quarterly res assessment. [sic] |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent Immediate Jeopardy level accidents and hazards resulting in a resident with a traumatic brain injury eloping from the facility through unsecured doors, accessing a public road and leaving the facility property, without staff supervision, for 1 (#1) of 9 sampled residents. This failure placed other residents at risk for elopement if they successfully exited out the unsecured doors not equipped with a wander guard alarm system, for 5 (#s 10, 11, 12, 13, and 14) of 9 sampled residents. The facility's failure increased the risk of serious bodily harm, injury, impairment, or death, due to the facility's failure to sufficiently address the doors the resident eloped from.<br><br>On 6/3/25 at 1:18 p.m., the facility Administrator, previous Interim Administrator, Administrator in-training, Director of Nursing, and Clinical Nurse Unit Manager were notified of an Immediate Jeopardy (IJ) situation, which involved resident #1. The IJ pertained to F689 - Free of Accident Hazards/Supervision/Devices.<br><br>On 6/5/25 at 4:40 p.m., the facility provided an acceptable plan to remove the immediacy for the residents residing in the facility who are at continued risk for elopement. The surveyor was onsite and did verify the removal of immediacy by observations, interviews, and record reviews. The Severity and Scope of the Immediate Jeopardy was identified to be at the level of K, and upon removal of immediacy, lowered to H.<br><br>Findings include:<br><br>1. Review of a facility reported incident submitted to the State Survey Agency, dated 3/28/25 at 9:50 p.m., showed resident #1 was last observed in his room on 3/28/25 at 7:15 p.m. He was seated in a lounge chair. At approximately 7:30 p.m., staff heard a door alarm and discovered a delayed egress door had been opened. The facility's elopement protocol was immediately activated. Facility staff confirmed resident #1 was no longer in the facility. This prompted a thorough search of both the interior and exterior of the facility. Police were contacted, and upon the officer's arrival, an individual who was outside reported seeing a man near a school, but the person was unable to provide an exact location. Resident #1 was located by law enforcement and returned to the facility on 3/28/25 at 7:57 p.m. The resident was alone and unattended for about 45 minutes, he left the facility property, and walked a good distance on his own.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an observation and interview, on 6/2/25 at 2:30 p.m., staff member E was present when a set of double doors were observed at the end of the crossroads unit. The windows on the double doors had white faux wood window blinds. The blinds were closed blocking the view of any person exiting to the outside. The double doors did not have a wander guard alarm system in place to alert staff of a potential elopement. The double doors opened to a vestibule that led to double egress exit doors which alarmed once the push bar on the door was pressed upon exiting. Staff member E stated resident #1 eloped from the facility on 3/28/25 at 7:30 p.m., and he exited out the emergency exit doors at the end of the hall on the crossroads unit. The unit was not occupied by residents or staff at the time of resident #1's elopement. Staff member E stated the exit doors at the end of the hall on the crossroads unit had not been secured with a wander guard alarm system in the last four years that she was aware of. Staff member E stated prior to resident #1's elopement, on 3/28/25, the resident would spend time on the memory care secure unit and would then be brought back to his room on the summit unit after dinner. Staff member E stated the facility's plan was to move resident #1 to the secure unit permanently, after the secure doors on the unit were moved, allowing a room to become available for resident #1. Staff member E stated resident #1 was moved to the secure unit on 4/7/25.<br><br>During an interview on 6/2/25 at 4:21 p.m., staff member C stated the wander guard alarm system was not installed on the exit doors on the crossroads and sapphire unit. Staff member C stated the wander guard alarm system was not needed on these units because the emergency exit doors had an alarm. The alarm sounded if a resident exited the facility. Staff member C stated the IDT reviewed resident #1 prior to discontinuing the 1:1 staff monitoring on 3/28/25. Staff member C stated she did not recall when the IDT met regarding resident #1, but a progress note or assessment should have been entered into the resident's EHR. Staff member C stated she was not sure if any measures were used in evaluating resident #1 during the IDT meeting, but the resident had been sleeping at night, and the IDT decided to trial the resident without a 1:1 monitor, on 3/28/25. Staff member C stated, Obviously it didn't work. Staff member C stated she would be most concerned about a resident who was an elopement risk exiting the facility and getting hit by a car.<br><br>During an interview on 6/4/25 at 5:20 p.m., staff member D stated on 3/28/25 he returned to the facility at 7:30 p.m. to pick up his phone. Staff member D stated he arrived and entered the facility's back parking lot. Staff member D stated he noticed the facility's emergency exit door was opened, and an alarm was sounding. Staff member D stated when he walked into the facility, the nurse told him an elopement occurred and resident #1 was missing. Staff member D stated he went back outside to look for resident #1. Staff member D stated two people were outside and stated they had seen an older gentleman at the school near the facility. Staff member D stated he returned to his vehicle and drove over to the school. Staff member D stated he did not see resident #1 at the school, but he did see a police car down the street in a residential area. Staff member D stated he arrived at the location of the police vehicle and observed resident #1 speaking to a police officer. Staff member D stated he approached resident #1 and encouraged him to come back to the facility. Staff member D stated the resident eventually got into the police vehicle and returned to the facility.<br><br>Review of resident #1's EHR showed resident #1 was admitted to the facility on [DATE] for skilled nursing services with a diagnosis of traumatic brain injury and agitation.<br><br>Review of resident #1's nursing progress notes showed the following:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/6/25 at 5:17 p.m., resident #1 eloped from the facility as staff accompanied him. No injuries were identified by nursing staff. Resident #1 became agitated and combative with staff, and the local police department was called to assist with transferring the resident back to the hospital. Resident #1's care plan was updated to include the resident was to be in direct line of site of staff at all times.<br><br>On 3/12/25 at 9:21 p.m. resident #1 eloped from the facility as staff accompanied him. No injuries were identified by nursing staff. Resident #1 became impulsiveness and was unable to be redirected. Resident #1 was transferred to the hospital for a psychiatric evaluation on 3/13/25. Resident #1 returned to the facility. Resident #1's care plan was updated, and a wander guard alarm was placed on the resident's left ankle with staff checking the device every shift to ensure it was functioning.<br><br>On 3/28/25 at 7:30 p.m., resident #1 eloped from the facility, going out double egress doors on a unit not occupied by residents or staff, and the doors were not secured with a wander guard alarm. The double doors opened to a vestibule and led to double egress doors, which alarmed once the push bar on the door was pressed, as exiting. Resident #1 left on foot, crossing the street and making his way down the block, unattended. The resident was found by the local police department at a residential location, 0.2 miles from the facility. Resident #1 was brought back to the facility by the police, and the nurse completed an assessment of resident #1. No injuries were identified. The resident's care plan was updated to resume 1:1 staff monitoring.<br><br>2. Review of resident #10's elopement risk assessments showed the resident was a risk for elopement on the following assessment dates: 9/6/24, 12/6/24, 3/6/25, and 6/3/25.<br><br>Review of resident #10's care plan, dated 6/3/25, showed the resident had a wander guard on his right wrist instructing staff to check the device every shift to ensure it was functioning properly.<br><br>3. Review of resident #11's elopement risk assessments showed the resident was a risk for elopement on the following assessment dates: 10/24/24, 11/8/24, 2/6/25, 5/8/25, and 6/3/25.<br><br>Review of resident #11's care plan, dated 4/2/25, showed the resident had a wander guard on her right ankle instructing staff to check the device every shift to ensure it was functioning properly.<br><br>4. Review of resident #12's elopement risk assessments showed the resident was a risk for elopement on 5/30/25 and 6/3/25.<br><br>Review of resident #12's care plan, dated 6/2/25, showed the resident had a wander guard on his left ankle instructing staff to check the device every shift to ensure it was functioning properly.<br><br>5. Review of resident #13's elopement risk assessments showed the resident was a risk for elopement on the following assessment dates: 12/16/24, 3/15/25, 4/14/25, and 6/3/25.<br><br>Review of resident #13's care plan, dated 4/15/25, showed the resident had a wander guard on his left wrist instructing staff to check the device every shift to ensure it was functioning properly.<br><br>6. Review of resident #14's elopement risk assessments showed the resident was a risk for elopement on the following assessment dates: 6/14/24, 7/24/24, 10/24/24, 11/26/24, 2/26/25, 5/26/25, and 6/3/25.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of resident #14's care plan, dated 6/3/25, showed the resident had a wander guard alarm on his left wrist instructing staff to check the device every shift to ensure it was functioning properly.<br><br>It was identified during the interviews and record reviews the wanderguard checks were not being completed as required.<br><br>During an interview on 6/2/25 at 5:00 p.m., staff member I stated she worked on the sapphire unit. Staff member I stated she did not know who checked the wander guard alarm system, but she believed it worked, because when a resident with a wander guard alarm device would get close to an exit door the alarm would start to beep.<br><br>During an interview on 6/3/25 at 9:00 a.m., staff member L stated she had one resident who was an elopement risk and the resident wore a wander guard alarm device. Staff member L stated the facility doors exiting outside to a public area have a wander guard alarm system installed on the door. Staff member L stated it was a facility regulation the system was installed on all doors exiting the facility. Staff member L stated if a resident who had a wander guard alarm device on moved to close to an exit door it would cause a beeping sound. Staff member L stated the beeping noise alerts staff to look in the area where exit doors are located, and staff can then redirect the resident prior to the resident exiting the door.<br><br>During an interview on 6/3/25 at 9:22 a.m., staff member J stated if she had a resident with a wander guard, she would take the resident close to an exit door to see if the device was working. Staff member J stated if the door started making a beeping noise, she would know the device was working. Staff member J stated she assumed all exit doors in the facility had a wander guard alarm system installed. Staff member J stated the wander guard door alarm system had a different sound than the doors which alarmed when the emergency exit doors were opened. Staff member J stated she responded to a wander guard alarm immediately; whereas if an emergency exit alarm sounded her response would not be immediate, because at times it would be a staff member using the door. Staff member J stated the emergency exit door was propped open, and the alarm was disarmed by staff.<br><br>Review of the facility document titled, (Facility Name) Elopement Policy and Procedure, undated, showed:<br><br>Policy Statement<br><br>It is the policy of the facility that all residents are afforded adequate supervision to provide the safest environment possible .<br><br>Procedure<br><br>1. Residents who have been assessed at risk for elopement/wandering shall be provided with a least one of the following safety precautions by the facility:<br><br>a. An adult electronic monitoring device will be used to notify/alert staff by sounding an alarm when the resident enters the perimeter around an alarmed door.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 2. As part of the facility's Preventative Maintenance Program, all door keypads will be checked for proper function daily by the Maintenance department/designee. These checks will be documented with date and time completed.<br><br>3. Residents with an adult electronic monitoring safety device will be checked every shift to ensure the device is in place.<br><br>4. Adult electronic monitoring safety devices will be checked nightly to ensure the device is functioning properly.<br><br>5. At no time shall a door alarm be turned off, without the continual supervision of the exit. *If the alarm must be turned off, it is the responsibility of the person disarming it to make sure it is functioning properly once the alarm is turned back on.<br><br>Routine Procedure for Wandering Residents and Prevention of Missing Residents/Elopement:<br><br>. 3. All residents at risk for possible elopement/wandering shall be accompanied by staff or a responsible party when leaving the residents unit and/or facility grounds.<br><br>. 5. When a door alarm sounds, staff members shall immediately respond to determine the cause of the alarm.<br><br>Routine Procedure for wandering Residents and Prevention of Missing Residents/Elopement:<br><br>. 5. When a door alarm sounds, staff members shall immediately respond to determine the cause of the alarm.<br><br>a. The staff responding to the alarm will check the outside of the area's building/vicinity to see if a resident has exited the building. [sic]<br><br>Review of a facility document titled (Facility Name) Facility Assessment dated, May 2025 showed:<br><br>. Staff Plan<br><br>. Licensed Nurses (LN): RN, LPN, LVN providing direct care<br><br>.The ratio of registered and licensed practical nurses to nursing aides shall be sufficient to assure professional guidance and supervision in the nursing care of the resident.<br><br>Each nurse is limited to one hall or designated number of rooms within the facility and has all patient room entrances and exits within sight from the nurse's station or medication/treatment cart. The exception is when coverage may be limited to one-night nurse. When this occurs, a medication aide will be used in the place of the 2nd nurse.<br><br>. |

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|---|---|
| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on interview and record review, the facility failed to ensure staff had the necessary education to monitor the functionality of the facility's wander guard alarm system for 6 (#s 1, 10, 11, 12, 13, and 14) of 6 residents sampled for wandering and elopement risk. This failure increased the risk for the resident's attempting to elope. Findings include:<br><br>During an interview on 6/2/25 at 5:00 p.m., staff member I stated she did not know who checked the wander guard alarm system, but she believed it worked because when a resident with a wander guard alarm device would get close to an exit door, the alarm would start to beep.<br><br>During an interview on 6/3/25 at 9:00 a.m., staff member L stated she had one resident who was an elopement risk and wore a wander guard device. Staff member L stated the facility doors exiting outside to a public area have a wander guard alarm system installed on the door. Staff member L stated it was a facility policy for the system to be installed on all doors exiting the facility. Staff member L stated she was not aware some exit doors in the facility were not equipped with a wander guard alarm system. Staff member L stated if a resident who had a wander guard alarm device moved close to an exit door, it would cause a beeping sound. Staff member L stated she did not know who was responsible for checking the device or door and did not know how often it occurred.<br><br>During an interview on 6/3/25 at 9:22 a.m., staff member J stated during her orientation she was shown by staff to take a resident with a wander guard alarm device close to an exit door to see if the device was working. Staff member J stated if the door started making a beeping noise, she would know the device was working. Staff member J stated she assumed all exit doors in the facility had a wander guard alarm system installed. Staff member J stated she did not know who was responsible to check the doors to make sure they were functioning or how often they were checked.<br><br>During an interview on 6/3/25 at 10:23 a.m., staff member H stated the maintenance department checked all facility door alarms once a month. Staff member H stated it was the responsibility of the nurses to check the wander guard alarm system daily to make sure the doors were functioning. Staff member H stated he did not have documentation of the daily testing completed by the nurses. No documentation was received from the facility which showed the wander guard door alarms were checked daily by the end of the survey.<br><br>During an interview on 6/3/25 at 2:00 p.m., staff member B stated the wander guard alarm system included a wand used by the nurses to check the device on a resident, and to check the doors equipped with the wander guard alarm system. Staff member B stated the wand was not currently used by the nurses, but moving forward the wand would be used to check residents' wander guard devices and doors.<br><br>During an interview on 6/4/25 at 4:35 p.m., staff member I stated the nurses on the skilled nursing unit were responsible for checking all facility doors equipped with a wander guard alarm system. Staff member I stated the process wander guard monitoring process was started today, (6/4/25), and no other documentation was available showing the doors were monitored prior to 6/4/25. Staff member I stated the wander guard alarm log was stored in the medication cart on the skilled nursing unit.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 275029 | A. Building<br>B. Wing | 06/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Yellowstone River Nursing and Rehabilitation | 2115 Central Ave<br>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 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Review of resident #1's care plan, dated 5/8/25, showed the resident had a wander guard alarm device on his left ankle instructing staff to check the device every shift to ensure it was functioning properly.<br><br>2. Review of resident #10's care plan, dated 6/3/25, showed the resident had a wander guard alarm device on his right wrist instructing staff to check the device every shift to ensure it was functioning properly.<br><br>3. Review of resident #11's care plan, dated 4/2/25, showed the resident had a wander guard alarm device on her right ankle instructing staff to check the device every shift to ensure it was functioning properly.<br><br>4. Review of resident #12's care plan, dated 6/2/25, showed the resident had a wander guard alarm device on his left ankle instructing staff to check the device every shift to ensure it was functioning properly.<br><br>5. Review of resident #13's care plan, dated 4/15/25, showed the resident had a wander guard alarm device on his left wrist instructing staff to check the device every shift to ensure it was functioning properly.<br><br>6. Review of resident #14's care plan, dated 6/3/25, showed the resident had a wander guard alarm device on his left wrist instructing staff to check the device every shift to ensure it was functioning properly.<br><br>During this investigation it was found nurses were not using the manufacturers device to check the wander guard system to verify device functionality for residents and facility doors.<br><br>Review of the facility document titled, (Facility Name) Elopement Policy and Procedure, undated, showed:<br><br>. Procedure<br><br>. 2. As part of the facility's Preventative Maintenance Program, all door keypads will be checked for proper function daily by the Maintenance department/designee. These checks will be documented with date and time completed.<br><br>3. Residents with an adult electronic monitoring safety device will be checked every shift to ensure the device is in place.<br><br>4. Adult electronic monitoring safety devices will be checked nightly to ensure the device is functioning properly. |