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	11/19/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to include person-centered information in the resident comprehensive care plan to include measurable objectives and timeframes to meet medical, nursing, and psychosocial needs for 2 (#s 1 and 4) of 8 sampled residents. This deficient practice increased the risk of resident #4 not having psychosocial needs met, and for staff assisting with resident #1's care to not follow enhanced barrier precautions to prevent infection. Findings include:During an interview on 11/19/25 at 9:50 a. m., staff member I stated nurses who admitted residents would begin a care plan for them. Staff member I stated charge nurses would add information and nursing supervisors as part of the IDT team would add information into resident care plans. Staff member I stated residents admitted to the facility with a foley catheter would have been started on enhanced barrier precautions. Staff member I stated that information would be added to a resident's care plan, to go along with TAR orders.During an interview on 11/19/25 at 2:29 p.m., with staff members B and C, staff member B stated nursing staff admitting a new resident would begin a resident's care plan. Staff member C stated the interdisciplinary team reviewed care plans when there was mental health, behavioral, or safety concerns with a resident newly admitted to the facility. Staff member B stated the interdisciplinary team, which included social services, added information to a resident's care plan when they were a new admission to the facility. Staff member B stated nursing supervisors added information to a resident's care plan following a interdisciplinary team meeting discussion to include changes in a resident's clinical status or treatment needs.1. Review of resident #1's MDS (Minimum Data Set) with an assessment reference date of 9/29/25, showed resident #1 was dependent on staff for toileting hygiene and required substantial/maximal assistance from staff for personal hygiene. It showed resident #1 had an indwelling urinary catheter and frequent episodes of bowel incontinence. Resident #1's primary medical condition was non-traumatic spinal cord dysfunction, and he had a diagnosis of obstructive uropathy.Review of resident #1's comprehensive care plan showed an admission date of 9/26/25. The care plan showed the following problems and interventions, initiated 10/14/25: .Focus. Potential for infection related complications r/t UTI .Goal. Infection will resolve with interventions through next review date.Interventions.- . ALERT CHARTING--Assess status of infection r/t UTI DOCUMENT SYMPTOMS, INTERVENTIONS and notify provider with any concerns. Monitor every shift for entire course of infection including 3 days post completion of antibiotics.- . Monitor for side effects of antibiotic treatment.- . Medications as ordered- . Treatment to affected area as needed- . Use good standard infection control precautions before and after providing care. [sic]Resident #1's care plan did not include specific information regarding resident #1's indwelling catheter related to enhanced barrier precautions, although the resident required frequent catheter changes and was at risk for potential UTIs.Review of resident #1's nursing progress note, dated 10/14/25 at 9:33 a.m., showed: LATE ENTRYNote Text: Infection - pt complained of increased difficulty with urination and increased amount of sediment noted in catheter. Catheter changed with sample obtained. pt culture results revealed e-coli and pt was placed on antibiotics for 7 days. will monitor for adverse reactions related to antibiotics. pt and family aware of treatment. [sic]2. During an interview on 11/18/25 at 2:35 p.m., staff member F stated resident #4 had expressed concerns to her about treatment by staff members including nursing staff and a provider. Staff member F stated she tried to build rapport with resident #4 in working with her, but resident #4 had a lot of emotional behaviors, and each day could be different. Staff member F stated her past work experience helped her recognize resident #4's mental health behaviors and cycling of emotions. Staff member F stated she notified a staff nurse to inform resident #4's provider of a request for mental health services. Staff member F did not state she added information to resident #4's care plan following these events.Review of resident #4's electronic medical record showed resident #4 was admitted on [DATE] with a diagnosis which included alcohol abuse (in remission). There were no other behavioral health diagnoses listed.Review of resident #4's care plan showed the following problems and interventions related to psychosocial wellbeing: . Focus . I have behaviors of manipulation and making up stories, I am very anxious Date Initiated: 09/09/2025. Goal. Minimal behaviors and mood disruptions. Interventions. Cares in pairs. Monitor for manipulative behaviors and attempt to redirect.Focus. Resident has paranoid tendencies with thoughts of people taking her personal belongings. Date Initiated: 09/19/2025. Goal. Resident will feel secure with belongings through the next review. Interventions. I have a lock box to store my personal belongings.Focus. I am taking Psychotropic Medications for depressiin Date Initiated: 09/08/2025. Goal. I want to be free of side

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a provider reviewed a resident's total program of care during a single visit with the resident, when the resident fired the physician who left not finalizing the visit, but then no other physicians attempted to finish the assessment, for 1 (#4) of 8 sampled residents. This deficient practice caused resident #4 to be at risk of not receiving medications, treatments, and services for maintaining physical, mental, and psychosocial well-being. Findings include:During an interview on 11/17/25 at 1:32 p.m., NF1 stated resident #4 fired the male provider who saw her for her initial visit, due to his bedside manner. NF1 stated resident #4 was concerned the provider did not listen to her, and things should have been straightforward to treat her GI issues. NF1 stated resident #4 was concerned that staff member D was dismissive towards her and did not fully hear her out. During an interview on 11/18/25 at 10:16 a.m., staff member D stated he visited residents in the facility who received services through [Hospital Name], and worked with [Staff Name] as the attending physician. Staff member D stated he had a visit with resident #4, which ended quickly due to the resident's emotional state. Staff member D stated, I was only in the room for five to ten minutes and was kicked out of the room; there was no physical exam done. Staff member D stated he was aware resident #4 fired him as her provider and stated she was allowed to do that. Staff member D stated he asked for resident #4 to have cares in pairs when staff went into the room to assist her, for her safety, and that of the staff. Staff member D stated the facility assists the resident with services of another provider, if the resident fired one, since the facility had physicians and non-physician practitioners who saw residents.During an interview on 11/18/25 at 12:58 p.m., resident #4 stated she went to the facility for rehab services after a hospital stay, due to different medical conditions. Resident #4 stated she had concerns with how staff treated her from the time she got to the facility. Resident #4 stated she tried to ask questions about her care and medications, and staff would get upset when discussing things with her. Resident #4 stated she requested a different provider due to concerns with how her assigned provider treated her, but she never got to see a provider after that first short visit.During an interview on 11/18/25 at 2:35 p.m., staff member F stated resident #4 had expressed concerns to her about treatment by staff members, including nursing staff and a provider. Staff member F stated resident #4 had fired her initial provider, and staff had attempted different ways and times to have her seen by a provider. Staff member F stated she tried to arrange for resident #4 to be seen by a different male non-physician practitioner, and the physician who oversaw staff member D. Staff member F stated resident #4 was offered to attempt a visit with staff member D, along with another staff member in the room, but resident #4 refused. Review of resident #4's provider notes, written by staff member D, dated 9/9/25, showed: . Today patient seated in wheelchair. She is quite tangential with mild pressured speech when describing a multitude of symptoms and comorbid conditions. Complains that left lower extremity remains weak since stroke like symptoms reported 9/3, unable to stand or ambulate where previously she was fully ambulatory. Describes hands and feet numbness, tingling and sharp pains. In my attempt to narrow her review of systems and history based upon complaints she was offering patient became upset and asked me to leave before I was able to complete my assessment or perform physical exam. Nurses consulted. Therapy team consulted. Vitals and MAR reviewed. Disposition: Based upon condition and comorbidities patient is appropriate for SNF stay, no anticipated discharge at this time. Reengage patient next visit to determine how best to serve her needs while at SNF. [sic]The provider failed to review resident #4's total program of care, when seeing the resident for one visit, while the resident resided in the facility for services. The provider was not able to assess resident #4's cardiopulmonary, GI/GU, musculoskeletal, neurologic, and psychiatric systems on 9/9/25. This did not allow resident 4's complete assessment for ongoing care and treatment. Resident #4 did not receive any other visits from providers, to include a full examination, history and physical, and recommendations while in the facility.Review of a facility policy titled, Comprehensive Care Plans, implemented 7/1/25, showed: . 7. The physician, other practitioner, or professional will inform the resident. of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assist a resident who requested mental health counseling to receive behavioral health services; when the resident had consistent documentation of emotional behaviors and concerns with her care staff that occurred since the date of admission, for 1 (#4) of 8 sampled residents. Findings include:Review of resident #4's electronic medical record showed resident #4 was admitted on [DATE] with diagnoses which included alcohol abuse (in remission). There were no other behavioral health diagnoses listed.During an interview on 11/18/25 at 12:58 p.m., resident #4 stated she went to the facility for rehab services after a hospital stay, due to different medical conditions. Resident #4 stated she saved notes and papers with information she kept from her time in the facility. Resident #4 stated she did not review them since her discharge because it would be retraumatizing. Resident #4 stated she had concerns with how staff treated her from the time she got to the facility. Resident #4 stated she tried to ask questions about her care and medications, and staff would get upset when discussing things with her. Resident #4 stated she felt staff at the facility covered for each other, so things were not resolved when she expressed concerns. Resident #4 stated she had submitted a grievance about the nursing staff and how they treated her. Resident #4 stated she requested a different provider due to concerns with how her assigned provider treated her, but she never got to see a provider after that first short visit. Resident #4 stated she tried to ask for help from staff member F, but things were not fixed during her time in the facility.During an interview on 11/18/25 at 2:35 p.m., staff member F stated resident #4 had expressed concerns to her about treatment by staff including nursing staff and a provider. Staff member F stated she tried to build rapport with resident #4 while working with her, but resident #4 had a lot of emotional behaviors, and each day could be different. Staff member F stated her past work experience helped her recognize resident #4's mental health behaviors and cycling of emotions. Staff member F stated she informed a staff nurse to inform resident #4's provider of a request for mental health services. Staff member F stated it was difficult because resident #4 had fired her provider, and staff attempted different ways and times to have her seen by a provider. Staff member F stated she had no record of any referrals made for resident #4 to receive counseling, therapy, or mental health services.During an interview on 11/19/25 at 2:29 p.m. with staff members B and C, staff member C stated the interdisciplinary team reviewed care plans when there were mental health, behavioral, or safety concerns with a newly admitted resident. Staff member C stated she met with resident #4 to review a grievance she filed, to discuss options for her care team staff. Staff member C stated some options discussed with resident #4 included having another staff member in the room for her assigned provider appointments, or firing of her assigned provider, with reassignment with another provider. Staff member B stated the interdisciplinary team, which included social services, would add information to a resident's care plan when they were a new admission to the facility. Staff member B stated she thought the facility used to provide telehealth counseling services through [Company Name]. Staff member B stated the social workers functioned in facilitating counseling services. Staff member B stated social workers had previously set up residents to have appointments with a telehealth provider in their rooms.Review of resident #4's grievance, dated 9/8/25, showed a concern related to her treatment, such as the staff would Grab my plate out of my hand and a CNA told the resident, We only have one CNA on this hall, and he can't be sitting here helping you. The resident denied abuse and wanted to be treated better. Review of resident #4's psychosocial assessment, dated 9/9/2025 at 12:19 p.m., showed: she was emotional and excitable, she was easily distracted, and had difficulty regulating her emotions. She has requested copies of all paperwork completed while in the facility. For her behavioral patterns, she was excitable and animated, easily distracted, and was emotional and crying off and on. Under the assessment for her mood and psychosocial well-being, the notes showed the resident was having difficulty settling in, and the facility was working through issues in regards to staff.Under section 9, the grievance reflected Yes was marked, showing the care plan was updated to reflect psychosocial well-being and mood components. Review of a section of resident #4's CAA (Care Area Assessment) worksheet completed by staff member F on 9/15/25, showed there was a referral to another discipline warranted, for the assessment by mental health and to address mental health concerns. Review of resident #4's nursing progress note, dated 9/9/25 at 2:54 a.m., showed: . she was very paranoid about medications. she was saying repeatedly things [NAME] right, this isnt right, i just dont get it tried to explain medications to her and reason for taking and she was concerned with vitamins and why i was not giving

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide individualized medically related social services, and accurately and thoroughly assess a resident, for her mood, behavior, and psychosocial status, and the resident displayed mood symptoms and took an antidepressant, displayed anxiety, paranoia, would often refused care, and act out toward others; and the facility failed to ensure her care plan included individualized interventions for care staff to use when the resident did display symptoms or concerns of the mood, behavior, or psychosocial concerns; and she was not referred for mental health services, although this was identified as necessary, for 1 (#4) of 8 sampled residents. Findings include: During an interview on 11/18/25 at 2:35 p.m., staff member F stated she tried to build rapport with resident #4, but resident #4 had a lot of emotional behaviors, and each day could be different. Staff member F stated her past work experience helped her recognize resident #4's mental health behaviors and cycling of emotions. Staff member F stated she notified a staff nurse to inform resident #4's provider of a request for mental health services. Staff member F stated staff attempted different ways and times to have resident #4 seen by a provider, but stated she had no record of any referrals made for resident #4 to receive counseling, therapy, or mental health services.During an interview on 11/19/25 at 2:29 p.m., with staff members B and C, staff member C stated the interdisciplinary team reviewed care plans when there were mental health, behavioral, or safety concerns with a resident newly admitted to the facility. Staff member B stated the interdisciplinary team, which included social services, added information to a resident's care plan when they were a new admission to the facility. Staff member B stated she thought the facility used to provide telehealth counseling services through [Company Name]. Staff member B stated that the social workers functioned in facilitating counseling services. Review of resident #4's psychosocial assessment, dated 9/9/2025 at 12:19 p.m., showed she had a BIMS of 17, but the highest score possible is 15. The resident was emotional and excitable, easily distracted, and had difficulty regulating her emotions. For her behavioral patterns, she was excitable and animated, easily distracted, and was emotional and crying off and on. Under the assessment for her mood and psychosocial well-being, the notes showed the resident was having difficulty settling in, and the facility was working through issues in regards to staff.Review of resident #4's social service note by staff member F, dated 9/19/25 at 10:17 a.m., showed, Resident is refusing to take prescription medication. resident is combative. Doctor attending to resident has been notified of her refusal to take medication. [Provider Name] PA has noted that resident has a long history of mental health concerns. No documentation was included to show how staff attempted to alter or provide interventions for the resident and for the refusals of care. A review of resident#4's Comprehensive MDS, signed as completed on 9/15/25, showed:-Resident #4 had a BIMS of 14; cognitively intact. She displayed disorganized thinking and inattention continuously. -Under section D -Mood, the resident score showed a 00 with no mood concerns identified. -Under Section E - Behavior, the resident showed she displayed no behaviors towards self/others. -Under section E900 - the resident was not coded as rejecting care. -Under section N, it showed the resident was taking an antidepressant but not taking a psychotropic medication. -For section V, for the CAAs, nothing triggered for mood or behavior. A request was made on 11/19/25 at 10:35 a.m., for referrals for behavioral health services for resident #4. No documentation was provided prior to the end of the survey.A review of resident #4's Progress Notes, from 9/17/25 to 9/22/25, failed to show consistent and individualized interventions staff attempted to utilize to assist with the resident when displaying symptoms of anxiety, depression, paranoia, manipulation, or rejection of care, although concerns were noted related to her mood, psychosocial status, and behavior. Several of the entries appeared to be carried over from prior entries added to the Progress Notes. A review of resident #4's care plan showed she had several issues related to mood/behavior, including:-The resident was taking a psychotropic medication for depression, initiated 9/8/25. There were no interventions for staff to utilize to assist the resident with the depression, other than monitoring the medications and side effects, and observing for changes.-The resident had paranoid tendencies, thinking others were taking her things, initiated on 9/19/25. The only intervention for this problem was a lock box, but there was nothing identified for staff to utilize in the event the resident displayed paranoia.-The resident would manipulate, make up stories, and was anxious, but again, there were no individualized and measurable interventions staff could use to alter or intervene in these behaviors when exhibited by the resident, other than to monitor or observe. Although the resident displayed a multitude of mood, behavior, and psychosocial concerns, these issues were not effectively addressed by the facility. Individualized

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility failed to hire and employ a full-time social worker who met the regulatory requirements and to meet the mood, behavioral, emotional, and psychosocial needs of residents. The facility was licensed for 160 beds. Findings include:During an interview on 11/18/25 at 2:35 p. m., staff member A stated that staff member F had been in the social services director position for about three months and held a degree in psychology. Staff member A stated the social services staff member prior to staff member F did not have a degree. Staff member A stated the other staff member who worked in a social services role (staff member E) did not have a degree.During an interview on 11/19/25 at 11:46 a.m., staff member A stated the facility's census had never reached 120 residents. Staff member A stated that since the census had never reached or went over 120, the facility met the social worker regulation with the two staff members in their social services roles. Staff member A stated the facility's census was currently 115, so they were getting a little nervous about that number. Staff member A stated the facility's corporate company had a licensed social worker who could oversee staff member F and act as a consultant as needed. Review of the facility's health care facility service license, dated 5/2/24, showed for the license specifications of Title 18/19 SNF (Skilled Nursing Facility), the facility was licensed for 160 beds.Review of a facility document titled, Job Title: Social Worker, which described staff member F's job description, showed: . QUALIFICATIONS. The requirements listed are representative of the knowledge, skill and or ability required. Education and Experience. - Bachelor's degree in Social Work from an accredited institution is required (Master's degree and/or experience in long-term care is preferred) .Certificates, Licenses, Registrations- Social Work license in the state employed is required.- Become familiar with and comply to all local, state, and federal regulations relating to the job.The document showed staff member F signed the job description on 8/18/25.Review of staff member F's academic transcripts and resume showed staff member F attained a bachelor's degree in psychology. The resume did not show a year of supervised social work experience in a health care setting working directly with individuals.A review of S483.70(o), the long term care regulatory requirements for a social worker showed, any facility with more than 120 beds must employ a qualified social worker on a full-time basis, which included one year of supervised experience in a healthcare setting. The regulatory requirement did not reflect that a facility was allowed to forgo employing a qualified social worker if the census was 120 or less. Refer to F656 - Comprehensive Care Plan, and F740 - Behavioral Services, related to concerns with a resident not receiving the necessary care and services for mood, behavior, and psychosocial concerns.