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	05/06/2026

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

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a Significant Change MDS (Minimum Data Set) assessment for a resident's change in condition, for 1 (#9) of 10 sampled residents. This deficient practice increased the risk of resident #9 not receiving services for his care to prevent further decline. Findings include:During an observation on 4/28/26 at 1:33 p.m., resident #9 was walking in a hallway on the secure care unit, following a housekeeper pushing her cart to his room. Staff member I stated resident #9 wanted to help the housekeeper with work, and he was usually interactive with staff. During an observation on 4/30/26 at 7:05 a.m., resident #9 walked in a hallway on the secure care unit outside of the activities room and stopped to talk with staff member J. Resident #9 asked her about what he could do now. Resident #9 gave staff member J a hug and a kiss on the side of her cheek and continued to talk with staff member J while walking down the hallway. During an interview on 5/6/26 at 2:53 p.m., staff member G stated he worked on MDS assessments for two days a week. Staff member G stated he would receive emails from staff member B about changes in a resident's condition that required a significant change assessment. Staff member G stated he also reviewed the resident's quarterly assessments to determine if a significant change assessment was needed. Staff member G stated that a Significant Change assessment should be completed when two or three resident care areas are changed. Staff member G stated he was not sure why resident #9 had not had a Significant Change assessment done after changes in condition were found in resident #9's quarterly assessments.Review of resident #9's diagnoses report showed he was admitted to the facility on [DATE] with pertinent diagnoses of Type 2 Diabetes Mellitus, Alzheimer's disease, and unspecified dementia. Review of resident #9's Quarterly MDS assessment, with an Assessment Reference Date of 12/12/25, showed:- Section E Behavior: no hallucinations or delusions, no behavioral symptoms exhibited, no rejection of care exhibited, and no wandering behaviors exhibited;- Section H Bladder and Bowel: no episodes of urinary or bowel incontinence;- Section K Swallowing/Nutritional Status: no changes in weight loss or weight gain, and therapeutic diet given while a resident.Review of resident #9's Quarterly MDS assessment, with an Assessment Reference Date of 3/13/26, showed:- Section E Behavior: delusions, verbal behavioral symptoms directed towards others occurred one to three days, other behavioral symptoms not directed towards others occurred daily, rejection of care occurred one to three days, and daily wandering behavior exhibited;- Section H Bladder and Bowel: occasionally incontinent of bowel;- Section K Swallowing/Nutritional Status: gain in weight of 5% or more in the last month or gain of 10% or more in the last six months and not on physician-prescribed weight gain regimen, and therapeutic diet given while a resident.Resident #9 had changes from quarterly assessments in care areas for behaviors, bladder and bowel, and nutritional status which had not been identified as a significant change in condition.Review of a facility policy titled, MDS 3.0 Completion, revised 5/5/25 showed: . 1. According to federal regulations, the facility conducts. periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. d. Significant Change in Status Assessment . - a comprehensive assessment completed within 14 days of the identification of a status change. i. A significant change is a major decline or improvement (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in a resident's status that: (1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. (2) impacts more than one area of the resident's health status, and (3) requires interdisciplinary review and/or revision of the care plan.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete and maintain resident documentation for PASARR (Preadmission Screening and Resident Review) assessment prior to admission for 1 (#9) of 3 residents sampled for PASARRs. The deficient practice increased the risk of resident #9 not receiving services for mental disorder or intellectual disability. Findings include:During an observation on 5/4/26 at 8:03 a.m., resident #9 was standing near the nursing station on the secure care unit. Resident #9 walked over to the surveyor standing by the medication cart. Resident #9 smiled and asked what he could do. Resident #9 patted the surveyor's shoulder after talking to the surveyor and walked over to staff member D near the medication cart. Resident #9 lifted his shirt and pointed to the right side of his abdomen, and stated to staff member D, Ouch, this hurts. Resident #9 walked away from the medication cart and followed staff member D as she left the medication cart to administer medications.During an interview on 5/4/26 at 4:03 p.m., staff member F stated she could only find resident #9's PASARR Level I screening. Staff member F stated she looked for a Level II screening for resident #9 and did not find any. Staff member F stated she did not know why a Level II screening would not have been done, but she had not been trained in her position to work on PASARRs.During an interview on 5/6/26 at 10:31 a.m., staff member E stated she worked in the admissions role in 2024 and would have worked on resident #9's PASARR screening in September 2024. Staff member E stated she would work on Level I screenings as needed when a resident was admitted to the facility. Staff member E stated she would complete them when they physically arrived at the facility. Staff member E stated she would update or redo a resident's Level I screening when more information was requested by the business office manager. Staff member E stated she worked on Level I screenings, and the business office manager handled anything after Level I screenings and Level II screenings.Review of resident #9's diagnosis report showed he was admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's disease and unspecified dementia. A diagnosis of cognitive communication deficit was added on 3/18/25.Review of resident #9's electronic medical record showed he was transferred to a local hospital for evaluation related to behaviors directed towards residents or staff members on:- 1/5/26,- 2/23/26,- 2/26/26,- 2/28/26,- 3/2/26.Review of a document for resident #9 titled PASRR Assessment - Level I, dated 9/6/24, showed: . Describe mental illness diagnosisUnspecified dementia, unspecified severity, with agitation. Describe indications of mental illnessresident is a&o to self .B. Mental Retardation or Related Conditions1. Does the individual have a diagnosis of mental retardation? * No. 3. Has the individual ever been referred to or served by an agency/institution serving persons with mental retardation or related conditions? * No . Approved: NoReferral for Level IIMental Retardation. [sic]Review of a facility document, sent by the facility on 5/7/26 at 10:46 a.m., showed a Level II request for resident #9 dated 9/18/24: A request for a Level II Preadmission Screening and Resident Review. evaluation to be completed for [Resident #9] was received on 9/16/24. [Resident #9] is not known to the Developmental Disabilities Program. An evaluator . will be contacted to evaluate if [Resident #9] meets the. definition of Developmental Disability, and to determine the need for any Specialized Services. Review of a facility policy titled, Resident Assessment - Coordination with PASRR Program, revised 5/5/25, showed: . a. PASRR Level I - initial pre-screening that is completed prior to admissioni. Negative Level I screen - permits admission to proceed and ends the PASRR process unless a possible serious mental disorder or intellectual disability arises later.ii. Positive Level I screen - necessitates a PASRR Level II evaluation before admission 2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission.3. A record of the pre-screening shall be maintained in the resident's medical record. 6. The facility designee shall be responsible for keeping track of each resident's PASRR screening status . 9. Any resident who exhibits a newly evident or (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a staff member provided safe transportation of a resident being transferred to the facility for admission for 1 (#10) of 10 sampled residents. The deficient practice caused resident #10 injury, resulting in a left ankle fracture, requiring hospitalization and surgery, which prolonged the resident's stay at the facility. The facility identified that the resident was not transported safely and immediately addressed and corrected the deficient practice before the survey, resulting in the findings of past non-compliance. Findings include:Review of a facility-reported incident, submitted to the State Survey Agency on 3/5/26, showed resident #10 was being transported from a local hospital to the facility for admission. Resident #10 was in a wheelchair in the facility van and was injured when the transportation staff member had to brake abruptly. The transportation staff member immediately called for emergency services assessment, and resident #10 was transported by emergency services to the hospital for evaluation of her left ankle pain and injury.Review of the facility reported incident's investigative findings, submitted to the State Survey Agency on 3/12/26, showed resident #10 was not properly secured in her wheelchair in the transport van. The transportation staff member involved was terminated for failure to follow safety protocols and standards of care. Resident #10 was admitted to the facility on [DATE] for rehabilitation, with psychosocial monitoring. The findings showed transportation staff were educated on safety protocols through competencies and return demonstration. Transportation staff received training on defensive driving and securing residents in wheelchairs for transport.Review of a facility document, dated 3/12/26, showed that a former transportation staff member was terminated from the position due to failure to follow established safety protocols and failure to meet expected standards of care and job performance related to the resident's transfer accident. The document showed the former staff member failed to properly secure a newly admitted resident in the facility van during transport to the facility. The failure resulted in the resident sustaining an ankle fracture from a fall, which was caused by the driver abruptly pushing the brakes while the vehicle was moving. The resident fell from her wheelchair because she was not secured in the chair. During an interview on 4/30/26 at 11:20 a.m., resident #10 stated she was injured when she was transported from a hospital on the way to the facility for admission in March 2026. Resident #10 stated she fell from her wheelchair because the facility driver did not secure her in with all the seat belts, and her chair had been moving around. Resident #10 stated she was very upset about the situation when it happened. Resident #10 stated she had been in pain, was hospitalized , and had surgery to repair her left ankle fracture. Resident #10 stated she was supposed to be admitted to the facility for rehabilitation following hip surgery. Resident #10 stated she had physical therapy for strengthening of her right leg scheduled, and services were added for her left ankle injury when she was finally admitted . Resident #10 stated that staff checked on her to see how she was feeling and doing often when she was admitted to the facility. Resident #10 stated she felt safe with the current facility driver.During an interview on 5/5/26 at 2:10 p.m., staff member A stated he had been in his role since 2025. Staff member A stated he was shown by a former staff member in the role of different duties and responsibilities. Staff member A stated he had not reviewed transportation staff competencies or education coming into the role. Staff member A stated the former transport employee who was terminated following the incident in March (2026) had been in his role since 2024. Staff member A stated that things had been going well with the former transport employee, and there were no complaints or concerns about his driving from residents. Staff member A stated that, looking back in hindsight, he should have verified transportation staff competencies and education.Review of a facility document, titled 3/5/26, showed that a former transportation staff member was trained by staff member A on the transportation staff's role in securing residents in wheelchairs in the facility (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	van.Review of facility documents titled Inservice Education Summary showed transportation staff were educated on resident seat belt safety on:- 3/24/26, - 4/14/26, - 4/17/26, and- 4/21/26.Review of facility documents showed transportation audit logs were reviewed and completed by staff member A weekly for residents being transported by drivers from 3/11/26 through 4/30/26.Review of a facility document titled Action Plan: Accident, dated 3/5/26, showed that a Quality Assurance and Performance Improvement meeting was held on 3/6/26 for the incident review for resident #10. The document identified the resident involved and corrective actions, the identification of others involved, systemic changes to prevent recurrence, and ongoing monitoring through auditing, for a compliance date of 3/7/26.Review of a facility policy titled Transporting a Resident (Facility Van or Vehicle), dated 6/10/25, showed: . 6. The van will be well-maintained and equipped with safety features. Each resident will be secured in a seat with a seatbelt or in their wheelchair secured with wheelchair tie-downs. 8. Staff authorized to drive the van will have the necessary training and licensure to operate the vehicle as well as knowledge on van safety features. Copies of any necessary documentation will be kept in each employee's personnel file.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure a resident at risk for nutritional deficits was provided a therapeutic diet and had fluids limited as ordered by a provider for 1 (#6) of 4 residents sampled for dialysis. This deficient practice increased resident #6's risk of experiencing hyperkalemia and fluid imbalance as related to end-stage renal (kidney) disease, when she required treatment for hyperkalemia (high level of potassium) and altered mental status resulting in hospitalization. Findings include:Review of resident #6's electronic medical record showed she was admitted on [DATE] with a primary diagnosis of end-stage renal disease, and pertinent diagnoses including: dependence on renal dialysis, heart failure, Type 2 diabetes mellitus, and hyperkalemia. During an interview on 5/6/26 at 12:53 p.m., staff member C stated she would review resident records and complete nutritional assessments each week at the facility, spending about eight to ten hours on the work. Staff member C stated she received communications from providers about nutritional needs and therapeutic diets for the residents. Staff member C stated she completed a nutritional assessment on resident #6 on 10/31/25. Staff member C stated she reviewed resident #6's hospital discharge documents and decided to keep her on a regular diet. Staff member C stated she did not always order a therapeutic diet if a resident had a condition like diabetes, renal failure, or heart disease. Staff member C stated it would depend on the resident's situation and review of labs, medications, and the resident's overall condition.During an interview on 5/6/26 at 3:18 p.m., staff member B stated that newly admitted residents were reviewed by the interdisciplinary team. Staff member B stated residents on dialysis would usually have diet orders reflecting a renal diet or taking supplements. Staff member B stated that nursing management would enter admission orders for the resident. Staff member B stated there were two staff members checking the admission orders that were entered for a resident. Staff member B stated the providers would enter physician orders into the electronic medical record system after they saw a resident.Review of resident #6's provider progress note, dated 10/29/25, showed: . Assessment/Plan:#Resistant hypertension. following with nephrology#Hyperkalemia, resolved.#Hyperlipidemia. - Cardiac diet.Review of resident #6's electronic medical record did not show any dietary order changes were documented after 10/29/25 to reflect the provider's plan for resident #6 to start on a cardiac diet with less than two grams of sodium daily, and less than two liters of fluids daily.Review of resident #6's nutritional assessment, completed by staff member C on 10/31/25, showed: . Initial assessment: End stage renal disease; dialysis; . hypertensive heart disease with heart failure. Medications: reviewedLabs: reviewedAlert/oriented, able to make needs knownDiet order: Reg/reg, consuming 50-100% of meals, independent w/eating, fluids offered.Monitoring: . intake . labs.Review of resident #6's care plan, dated October 2025, showed: . Focus: Alteration in Blood Glucose due to hyper/hypoglycemia.Interventions:- Observe for high blood sugar symptoms - increased thirst, increased hunger, increased urinary output- Observe for low blood sugar symptoms - flushed face, sweating, change in usual mental status. Focus of: Diet/Eating: . I am on a regular diet/regular texture/thin liquidsInterventions: I receive a regular diet. Focus: Potential for complications . for Malnutrition Nutrition Score:8.Interventions:- Diet as ordered by physician- Nourishment/supplements as ordered .- RD to evaluate for recommendations for nutritional/calorie needs .The care plan failed to show a therapeutic diet order and fluid restrictions as ordered by a provider on 10/29/25 to meet the needs of resident #6's multiple clinical conditions.Review of resident #6's nursing progress note, dated 11/3/25 at 9:06 p.m., showed: . daughter located this writer on 300 halls stating, my [resident] is not acting right. I am about to call 911. This writer went to residents' room to assess resident. She was alert but would not answer any questions. Explained to [family member] that resident labs showed K+ to be elevated and provider had ordered new medications to decrease her K+ which she declined until . 6pm. I did aske resident if she would like to go to ER for eval and she stated yes. [sic]Review of resident #6's electronic (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record showed resident #6 had not received the provider's ordered diet and fluid restrictions for five days, from 10/29/25 to 11/3/25. Resident #6 was transferred to a local hospital on [DATE] and did not return to the facility.Review of a facility policy titled Therapeutic Diets, dated 1/2026, showed: The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals. Therapeutic Diet is a diet ordered by a physician, or delegated registered or licensed dietitian, as part of the treatment for a disease or clinical condition. It also may be ordered to eliminate, decrease. specific nutrients. Examples include low salt, diabetic, or low cholesterol diets. 2. Therapeutic diets. will be based on the resident's individual needs. may be considered in certain situations.a. Inadequate nutritionb. Nutritional deficits .d. Medical conditions such as diabetes, renal disease, or heart disease. 5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to complete an assessment of a resident's health status prior to and after returning from the dialysis center for 2 (#s 2 and 6) of 4 sampled residents receiving dialysis treatments. This deficient practice increased the risk of residents #2 and #6 to experience adverse outcomes related to complications from end-stage renal disease. Findings include:1. Review of resident #2's electronic medical record, dated February 2026, showed an admission date of 2/10/26, with pertinent diagnoses including end-stage renal disease, Type 2 diabetes mellitus, anemia in chronic kidney disease, and dependence on renal dialysis.Review of resident #2's medication administration record, dated February 2026, showed orders initiated on 2/11/26 for weights and pre and post dialysis assessments to be completed every day shift on Mondays, Wednesdays, and Fridays.Review of resident #2's electronic medical record showed facility staff failed to obtain resident #2's weight on 2/23/26 and 2/27/26. Facility staff failed to complete a post-dialysis assessment on 2/23/25.2. Review of resident #6's electronic medical record showed she was admitted on [DATE] with a primary diagnosis of end-stage renal disease, and pertinent diagnoses including: dependence on renal dialysis, heart failure, Type 2 diabetes mellitus, and hyperkalemia. Review of resident #6's medication administration record, dated October 2025, showed dialysis assessments were to be completed before and after dialysis every Tuesday, Thursday, and Saturday.Review of resident #6's electronic medical record, dated October 2025, showed facility staff failed to complete dialysis pre and post assessments on 10/25/25 and failed to complete a pre assessment on 11/1/25. Resident #6 refused dialysis on 10/28/25 and 10/30/25, but facility staff failed to document the refusal of dialysis on 10/28/25 or 10/30/25 on a pre and post assessment form. Facility staff failed to document on 10/28/25 any staff communication to explain the risks or provide education of refusal of dialysis to resident #6, or to notify the provider of refusal.During an interview on 5/6/26 at 3:11 p.m., staff member B stated nursing staff were to obtain vital signs and complete a pre and post assessment of a resident receiving dialysis. Staff member B stated it was important to see how much fluid was taken off, and if any medications were given. Staff member B stated if something significant happened to a resident the provider should be notified, and if there was a refusal of dialysis, the provider should be notified. Staff member B stated there should be a monitoring for change in condition if a resident refused dialysis, with a documented nursing note stating risks.Review of a nursing protocol, titled, Dialysis patients, not dated, showed: 1 Obtain vitals pre and post treatment as well as a weight pre and post on respective dialysis days2 Complete. Dialysis Pre & Post Assessment EACH and every day they have dialysis. [sic]Review of a facility policy titled, Hemodialysis, revised 5/1/25, showed: . The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include:- The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. 3. The facility will coordinate and collaborate with the dialysis facility to assure that:a. The resident's needs related to dialysis treatments are met;. c. Documentation requirements are met to assure that treatments are provided as ordered. 4. The facility will monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment and will inform the attending practitioner. 10. The facility will communicate with the attending physician . of any canceled or postponed dialysis treatments and document any responses to the changes in treatment in the medical record.Review of a facility policy titled, Residents' Rights Regarding Treatment and Advance Directives, revised 6/10/25, showed: . 11. Should the resident refuse treatment of any kind, the facility will document the following in the resident's chart as applicable.a. What the resident refused.b. The reason for the refusal.c. How the resident was educated regarding the consequences of refusal f. That the physician was notified of refusal and the resident's response to education/offering of alternatives.

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure medications were transcribed into a resident's electronic medical record accurately, and failed to identify a high-risk medication ordered for a resident with end-stage renal disease for 1 (#6) of 4 residents sampled for dialysis. This deficient practice resulted in resident #6's altered mental status, requiring hospitalization and treatment. Findings include:During an interview on 5/6/26 at 3:20 p.m., staff member B stated residents were reviewed by the interdisciplinary team as new admissions, and nursing management would enter admission orders. Staff member B stated there were two staff members to check the admission orders that were entered, so they would not miss something with an order. Staff member B stated that if a resident was transferred from a hospital as a new admit, discharge orders were entered by nurse management. Staff member B stated it must have been a mistake that a couple of orders were entered differently from discharge orders for resident #6. Staff member B stated that providers entered orders after they saw a resident. Staff member B stated if there was a medication that was high-risk, the system sometimes had an alert of an interaction. Staff member B stated that when providers entered physician orders, the orders would be pending confirmation until a nurse reviewed the order. Staff member B stated that the staff trusted the providers with what they ordered for the residents. Staff member B stated she did not know that nurses would question an order for Baclofen given to a resident on dialysis. Staff member B stated she did not know if there was a warning of a medication interaction alert that appeared for providers when they entered orders in the system.Review of resident #6's hospital discharge orders, dated 10/24/25, showed: Carvedilol 6.25 mg oral tablet. Take 1 tab(s) (6.25 mg) by mouth 2 times a day .Clonidine 0.1 mg oral tablet. Take 2 tab(s) (0.2 mg) by mouth 2 times a day .Review of resident #6's medication administration record, dated October 2025, showed: . Carvedilol Oral Tablet 6.25 MG. Give 1 tablet by mouth one time a day for Hypertension -Start Date- 10/25/2025. cloNIDine . Oral Tablet 0.2 MG. Give 1 tablet by mouth one time a day for Hypertension -Start Date- 10/25/2025Review of resident #6's nursing progress notes, dated 10/24/25 at 2:03 p.m., written by staff member B, showed: . This order is outside of the recommended dose or frequency.Carvedilol Oral Tablet 6.25 MG Give 1 tab by mouth one time a day for Hypertension- The frequency of daily is below the usual frequency of 2 times per day.The facility nursing staff did not transcribe admission orders for resident #6 correctly, by entering a lesser dose than was ordered for antihypertensive medications.Review of resident #6's provider progress note, dated 10/31/25, showed: . Assessment/Plan:. #Resistant hypertension. following with nephrology#Hyperkalemia, resolved. -Dialyzes Tuesday/Thursday/Saturdays-I do wonder if hyperkalemia is exacerbated by telmisartan double max daily dose, review of past notes show that this is consistent.#Chronic back pain. -Schedule Dilaudid . Trial baclofen 5 mg bid . Patient verbalizes understanding and has no further questions. - Previously ineffective treatment/adverse effects with Tylenol #3, oxycodone, tramadol, gabapentin, fentanyl patch, Flexeril. [sic]The facility staff failed to take into context the high-risk associated with the use of a muscle relaxant (Baclofen). Resident #6's end-stage renal disease and her pattern of refusal of dialysis treatments, placed her at high-risk for medication toxicity. The provider documented that risks, benefits, and alternatives were reviewed with resident #6. Review of resident #6's nursing progress note, written by staff member H, dated 11/3/25 at 5:54 p.m., showed: Note Text: Resident lethargic this shift, Received critical potassium notification. Provider notified in house at bedside and orders received. Resident refusing medications . [sic]Review of resident #6's physician progress note, dated 11/3/25, showed: . #Hyperkalemia . potassium of 6.2 this morning. Patient is to get dialysis tomorrow. Hyperkalemia is thought to be secondary to missing dialysis last week. At this point I wish to avoid extended release opiates. The family was very concerned today about her slow breathing in the room. I expressed to them that with potent opiates that she is on. as well as her decreased renal function on hemodialysis, missing dialysis (as happened last week), will cause narcotics to build up in her system and increase her (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 B. Wing	05/06/2026

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

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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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	sedation. Nursing staff was very concerned today as patient was initially not arousable and sternal rub had to be used to wake patient in the morning. Because of this we decreased her Dilaudid. We also stopped her baclofen. Of note, at this time patient is full code. [sic]Review of resident #6's transfer form, dated 11/3/25 at 7:52 p.m., showed that a transfer to a hospital emergency room by a staff nurse was completed. The document showed the reason for transfer was for Other family/patient request. Vital signs recorded at 7:48 p.m. showed resident #6's blood pressure was 201/101, and pulse oximetry reading was 92%.Review of resident #6's hospital physician progress note, dated 11/5/25, showed: . Patient presenting to the hospital with encephalopathy initially thought to be hypertensive emergency but with improvement following dialysis rather than blood pressure reduction, highest suspicion is for . baclofen toxicity . Would recommend discontinuing and never restarting this medication. It has been adder to her adverse reaction/allergy list. [sic]Review of a facility policy titled Provision of Quality Care, dated 6/10/25, showed: . 1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. 4. Qualified persons will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices.