

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Billings Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 S 27th St Billings, MT 59101	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48268</p> <p>Based on observation, interview, and record review, the facility failed to prevent Immediate Jeopardy level neglect by refusing to allow a resident re-entry to the facility after transferring to the hospital, then he went AMA, and attempted to return to the facility, which resulted in the resident sitting outside of the facility for several hours in inclement weather, and placing the resident at high risk of a serious adverse outcome, for 1 (#1) of 3 residents sampled for discharge.</p> <p>On 6/6/24 at 1:06 p.m., the facility Administrator and administrative staff were notified of an Immediate Jeopardy involving resident #1, pertaining to F600 - Freedom from Abuse and Neglect. The facility provided an acceptable plan to remove the immediacy for the resident involved, and the time the immediacy was removed was at 4:58 p.m. on 6/6/24. The surveyor was onsite verified 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 J, and upon removal of immediacy, lowered to G.</p> <p>Findings include:</p> <p>During observations, interviews, and record reviews, the following was found:</p> <p>Resident #1 was denied entry to the facility on two separate occasions during one shift on 5/23/24, despite an administrative directive relayed to staff member D at 1:14 a.m. to allow the resident entry to the facility. The denial of entry resulted in resident #1 sitting in the parking lot for approximately four hours overnight in inclement weather. Details of the observations, interviews, and record reviews included:</p> <p>During an interview on 6/3/24 at 3:48 p.m., staff member C stated, staff member D contacted her by phone at approximately 12:15 a.m. to report resident #1 had signed out of the hospital against medical advice (AMA). Resident #1 had taken a cab to the facility, and the cab driver was requesting entry for resident #1. Staff member C reported being called into the facility at approximately 12:30 a.m. at the request of staff member D. On arrival at the facility, staff member C messaged staff member A and also left a message for the on-call provider.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Staff member C stated resident #1 had left the facility with the cab driver, on another run by the time of her arrival. Staff member D told staff member C the cab driver left his phone number and was waiting for instructions on where to leave resident #1. Staff member D did not have instructions from administration or admitting orders at that time. Staff member C stated she received a text from staff member A on 5/23/24 at 1:14 a.m., instructing the staff to, Let him (#1) rest at the facility for the night, and we can figure this out in the morning. Staff member C reported she told staff member D about staff member A's instructions.</p> <p>Staff member C stated she left the facility to return home at approximately 1:30 a.m. on 5/23/24, and resident #1 had not returned to the facility while staff member C was there. Staff member C stated she did not see resident #1 in the parking lot, or on the bench near the entrance, as she left the parking lot to return home. Staff member C stated, He's a problem. By 4:00 a.m., (resident #1) would be throwing things if he didn't get his medicine. Staff member C did not know if anyone from the facility assessed resident #1 at any time or confirmed his identity. Staff member C stated she did not follow-up with the on-call provider before or after returning home related to #1's need to return to the facility.</p> <p>During an interview on 6/4/24 at 5:18 p.m., staff member D stated, I got a call from the hospital, I think it was about 12:15 a.m. (on 5/23/24), and the nurse said (resident #1) had decided he didn't want to be there anymore, and he was on his way back in a cab. The first thing I did was call (staff member C) to see what I should do, because he was discharged from our facility when he went to the hospital. Then the cab driver came to the door and said he had (resident #1) out in his cab, and I hadn't heard back from anyone yet. (The cab driver) said he would just keep (resident #1) in the cab, and said he had another call to go on. (The cab driver) gave me his phone number and said to call him when I knew what we were going to do. When I heard back from (staff member C), she said she was on her way in, and we decided the best thing to do, because I didn't have any orders or anything, was to let him go back to the ER because that's where he needed to be because he was sick. I called the cab driver around 1:15 a.m. and asked (the taxi driver) to take (resident #1) back to the emergency room . Staff member D stated she did not follow-up with the hospital or the on-call provider, and did not call resident #1's primary physician, stating, . because there is no doctor in the middle of the night who is going to give (physician) orders, and this man was a heavy narcotic user, and I knew that as soon as he came in the door he was going to want narcotics. Around 4:00 a.m., someone came to the door, and they (the CNAs) said it was a lady, and she was not very nice. (The lady) said that there was an old man sitting out on the bench. I had no idea who she was or that it was (resident #1), and so she just went away. There was no conversation. The lady was outside yelling and said she was going to call the police, and there's an old man sitting (outside the facility), and then she left. She did not say his name, and I was certain it was not (resident #1) . We have video cameras, but there was no camera in that (front entrance) area. I was certain it was not my resident because he could have come to the door. He was able to walk to the door, and I thought if that was my resident he would have come to the door himself. When the police came, the police officer said that this old man was out there, and nobody ever said his name, and I just told her when someone leaves the facility and goes to the hospital they're discharged until they're readmitted . (The police officer) didn't know it was a resident, or didn't say it was. (The police officer) was only there a minute, and then she just left, and took him (#1) with her . all I know for sure is that I was positive that it wasn't (#1).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/24 at 7:20 p.m., staff member I stated, I think the lady that was here around 3:00 or 4:00 a.m. (on 5/23/24) called the cops. I think so, because the nurses kept telling them that they couldn't take him (#1) back in because of no (physician) orders. I think that's why the lady called (the police), and that made a big old stink about it, because we couldn't let him back in. In the back of my head, I was wondering why (the nurses) didn't just let him back in. (Staff member E) was working that night and kept saying that (#1) had to have an (physician) order before they could let him back in. They knew who he was, definitely. After the cop left, then everybody came back up to the nurse's station, and started talking about it.</p> <p>During an interview on 6/5/24 at 8:00 a.m., staff member A stated he probably should have reported the incident. Staff member A stated he did obtain statements from some of the staff that were working on 5/23/24, but did not complete a thorough investigation.</p> <p>During an interview on 6/5/24 at 11:50 a.m., staff member A reported the facility video footage from the front entrance camera, as requested by the surveyors, was being deleted due to space capacity as administrative staff were reviewing it. (The facility) would therefore be unable to provide video footage for surveyor review. Staff member A stated the staff took notes and would provide written statements of what they had observed on video for the early morning hours of 5/23/24.</p> <p>During an interview on 6/5/24 at 11:11 a.m., NF2 stated, I picked (#1) up in my cab at [Hospital]. He wanted to go to the nursing home. I went to the (facility) door and they told me he couldn't come in. I was kind of sad about how that all happened . because I don't know why they didn't want him to have a place to stay another day. It was a nursing home decision they couldn't have a place for him to stay. [Resident #1] had to go to the hospital first and talk to the doctor, and he didn't want to go, and it's kind of sad all the way around. [Resident #1] was so weak, but I just had to leave him there (at facility). [Resident #1] said the last thing he wanted to do was go to the hospital, and I couldn't convince him to, so I just helped him get in his truck at the nursing home.</p> <p>During an interview on 6/5/24 at 4:20 p.m., staff member J stated, Around 11:30 a.m. (on 5/23/24), one of the CNAs came and got me and told me [Resident #1] was in his truck. I went out there because he just found out he had cancer and was so weak. He told me he wanted to smoke a few cigarettes, and so I said I'd be back in about 20-30 minutes, because I knew he was going to need a wheelchair. I don't even know how he got into his truck, because he was that weak. I brought him back to his room, and I asked him what happened, and he said he came here in a cab and [Staff member D] told the cab driver the facility could not accept the resident again as they didn't have (physician) orders, and he needed to go back to the hospital. The cab driver said he'd take him back to the hospital, so I asked him if he went back to the hospital, and he said, 'No, I stayed right here (in the parking lot) until the newspaper lady found me on the bench.' You could just tell he knew he was dying. I think he was just so much thinking about that and what he found out in the hospital. We put him in bed, got him blankets from the (blanket warmer). He just stayed in his room, you know, that's how we knew he was going downhill over the last couple weeks, but he was so stubborn he didn't want to go to the hospital. He just looked so tired and defeated like he was in a lot of pain.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/24 at 11:17 a.m., NF3 stated, At around 4:15 a.m. (on 5/23/24), [Resident #1] was sitting on the bench near the front of [Facility], and as I delivered the newspaper, I heard yelling, Help me, help me, help me! I saw [Resident #1] sitting on the bench waving his arms. It was raining and cold out, so I stopped and asked him what was going on. [Resident #1] said he could not stand up. I got out of my car and tried to help him. I was not strong enough to help him up because it is like dead weight when somebody can't lift themselves off a bench. [Resident #1] said he had been stuck sitting there on the bench for a long time. He asked if I could please help him get up because he can't on his own. He had a cane with him and did not have a coat. I tried to help him up three times and was unable to. I then said, let me go and ask the nurses for help. I rang the doorbell. I could see the staff sitting at the nurse's station. Eventually three staff members got up and came over to the inner door, but they did not want to open the door. There were two sets of doors with a space between maybe six feet or so. I had to talk to the staff through both glass doors, so I was talking pretty loudly. One of the staff, she was young and had pink hair, she cracked the door and said, 'He [Resident #1] doesn't stay here so it's not our deal.' I said excuse me? The same person said, 'Yeah, he doesn't stay here, so we're not going to help him.' I said, well OK, so will you please then call the non-emergency (police) number because I'm not strong enough to get [Resident #1] to stand on my own. The staff refused. I was floored by their complete lack of caring. I said this is an older gentleman, and he cannot stand on his own. I asked if they would please call the non-emergency (police) number, and the staff member said no, and repeated it several times. I was not cool, calm, or collected, because I was getting very upset with the way they were handling the situation. I said to the staff, to be clear, you are refusing to call the non-emergency (police) number to help an old man in need that's trapped on your bench in front of your facility. The staff member said yes. I said alright, and went and called the non-emergency (police) number to report it. [Resident #1] was still on the bench in the rain without a coat. [Resident #1] said, 'Well maybe if I scoot to the very edge of the bench, you'll be able to get more leverage and help me.' I said OK, and tried a fourth time to help him and was not able to. At that point, I told [Resident #1] they're not going to help you because you don't live here, and he said, 'Yes, I do live here. My name is [Resident #1] and I live in room [room #]. My name is on the door. I was just released from the hospital and dropped off here.' At that point, I went back to the doorbell and told the nurses who the gentleman was, and they all looked up at me, but no one even got up or came to the door that time. When the police arrived, one officer asked [Resident #1] some questions, while the other officer went inside the building. [Resident #1] seemed a little flustered and anxious, maybe a bit confused during questioning. He was weak, cold, and he just got out of the hospital. It was a pretty overwhelming situation. He looked like he was in pain. While the officer asked questions, I went and got a blanket from my car and wrapped him in it. I gave the police officers my card, and told them if they needed any more information, I would be happy to give it to them. The nursing staffs' behavior was unacceptable. They have taken an oath as healthcare providers, and that's something that they should uphold whether it's somebody that lives in the facility or not. My concern was [Resident #1]. To leave somebody who has just been discharged from the hospital sitting outside in the rain and cold without a coat is very concerning. Older people are so susceptible to pneumonia or other types of infections. I'm very happy that I came along when I did, because I normally don't start that route first. So it was just happenstance that I was in the right place at the right time. How long would he have been out in that weather if I hadn't come by?</p> <p>Review of resident #1's progress notes, showed the following entry, signed by staff member D, and dated 5/23/24 at 6:23 a.m.:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Received call from [Local Hospital] (12:00 a.m.) stating this resident had left hospital AMA and was heading back to facility in a cab. Called administration to ask what to do. ADON attempted to call administrator and DON, then came to facility. Resident is outside in the cab, and when we had not heard back from administration told cab driver to take him back to the ER. Cab left with resident inside. Later, a girl rang the door bell and stated there is an old man sitting on the bench, and she was going to call the police. police arrived, explained to her this resident was discharged from the facility, he left the hospital AMA, and we have no idea how he got back here and on the bench. Police left with resident. [sic]</p> <p>Review of resident #1's progress note, showed the following late entry, signed by staff member C, and dated 5/23/24 at 6:32 a.m.:</p> <p>Called by NOC nurse (staff member D) at approx. 0015 (12:15 a.m.) - stating that hospital called to say resident had checked himself out AMA and was heading back to facility by cab. Notified Admin of above and for advice- called (Hospital) on call- to attempt to get order to readmit- no return call from [provider name] the on-call provider. Cabby told [staff member D] that resident could not even walk, I told [staff member D] to have cabby take resident back to the hospital, with him being that sick. Cabby told [staff member D] that he would keep resident with him for another run. After this discussion, Administrator text back to keep the resident here until morning and we would then figure this out. I told [staff member D] on the advice of the Administrator; we were to keep resident, and we could figure this out then. Nothing more was heard from the cabby and or resident until about 0430 (4:30) a.m., when [staff member D] called back to say that someone from the outside had called the police because we were not taking care of our residents and he had been sitting outside. Police asked who the administrator was and gave them his name and number. When I got here this am, [staff member D] told me that the police took him with them. [sic]</p> <p>Review of the hospital on-call provider call log and audio recording, dated 5/23/24 at 12:39 a.m., showed one call was placed to the on-call provider line regarding resident #1. On the call recording, the operator is heard telling staff member C, They should call you within ten minutes, if not give us a call back, and we will reach out to her cell phone.</p> <p>Review of resident #1's MDS Discharge Assessment, with an ARD date of 5/21/24, showed resident #1's discharge coded as an unplanned discharge, Short-Term General Hospital, and return anticipated.</p> <p>Review of resident #1's medical record showed a signed Bed Hold, dated 5/21/24.</p> <p>Review of a police report, dated 5/23/24 at 4:38 a.m., showed the weather conditions were raining, 46 degrees Fahrenheit, and 93% humidity. Two officers responded to the call at [Facility name]; NF4 and NF5.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of NF4's body camera footage showed an on-scene arrival at the facility at 4:23 a.m. on 5/23/24. The footage showed NF4 talking with the facility staff. NF4 stated, Do you have a [Resident #1] listed here at all? Staff member D stated, He's in the hospital. NF4 stated, He's been released, he's sitting on the curb right now. Staff member E stated, He left AMA. Staff member D stated, He left here in a cab. He was on his way to the ER. NF4 stated, So does he not have a room here, then? Staff member D stated, No he was discharged . Staff member E stated, As far as we're concerned, he's just somebody, who, like anybody walking in off the street and saying, yeah I have a room here. Staff member D stated, How he got out of the hospital and got back here, nobody called us, nobody told us, but we couldn't let him in here anyway because he was dismissed. NF4 left the facility parking lot in route to the hospital at 4:37 a.m. At no time in the video footage, did any facility staff express concern for resident #1's health or well-being, and no facility staff went outside with the officer to identify, assess, or assist resident #1.</p> <p>Review of NF5's body camera footage, showed an on-scene arrival at the facility at 4:23 a.m. on 5/23/24. Resident #1 was observed sitting outside of the facility on a bench talking with NF3. Resident #1 was wearing a lightweight button-up shirt with T-shirt underneath, and lightweight pants. Resident #1 was in the rain and his clothes were wet. He was attempting to protect his face and head from the rain and cold with his shirt collar. Resident #1 appeared weak and frail. He was grimacing in obvious discomfort and was having difficulty breathing. NF3 told resident #1 she was going to get him a blanket, and she is observed in the background wrapping the resident in a blanket. The officer asked if resident #1 would like to get into the patrol vehicle to warm up and resident #1 said Yes. You're going to need to help me up. Once upright, resident #1 walked to the patrol vehicle with a slow, shuffling gait and using a cane for support. His breathing was labored, and he was in obvious discomfort. NF5 stated, Are you supposed to be on oxygen? Resident #1 stated Haven't been, but . I told them regularly that they should put me on some . Resident #1 is heard moaning in the backseat of the patrol vehicle, as he tried to find a comfortable position, and he was heard coughing. NF5 asked resident #1 if his belongings were still in the facility, to which he replied, yes. NF5 arrived at the hospital at 4:42 a.m. Resident #1 was polite and appreciative of the officers' assistance and thanked them at the hospital.</p> <p>Review of resident #1's Emergency Department Report, dated 5/23/24, showed the following:</p> <p>This is a [AGE] year-old male presenting to the emergency department via (local police). Patient was admitted to the hospital, left AMA last night May 22, 2024 at approximately midnight. He returned to his . facility ., however he was not allowed back into the building stating that he needed medical evaluation . As result he was left on the bench outside. Police found the patient sitting on the bench in the rain. As (a) result, they brought him back to the emergency department for evaluation . wishes to return back to the rehab facility where all of my stuff is. [sic]</p> <p>Based on the information above in the observations, interviews, and record reviews, facility staff continued to deny the resident entry, stating he did not have a room there, and they could not let him in. None of the facility staff that were observed on police body camera video showed concern for resident #1's well-being, and no facility staff were observed going outside with the officer to identify, assess, or assist the resident. No follow-up call was placed to a provider for admission orders. Resident #1 was in fragile health, and the refusal of the staff to allow the resident to enter the facility put resident #1 at high risk of a serious adverse outcome due to his health and general safety.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48262</p> <p>Based on interview and record review, the facility failed to report to the State Survey Agency a facility reported event involving a resident who was denied reentry after discharging against medical advice from an acute hospital for 1 (#1) in the required timeframe; and failed to report incident findings to the State Survey Agency within the five-day required time frame for 11 (#s 2, 3, 5, 6, 8, 9, 10, 11, 12, 13, and 14) of 14 sampled residents. Findings include:</p> <p>1. Review of resident #1's electronic medical record nursing progress note, dated 5/23/24 at 6:12 a.m., showed staff member D stated, Received call from [Hospital Name] 2400 (12:00 a.m.) showing this resident had left hospital AMA and was heading back to facility in a cab. Called administration to ask what to do. ADON attempted to call administrator and DON, then came to facility. Resident is outside in the cab, and when we had not heard back from administration told cab driver to take him back to the ER. Cab left with resident inside. Later a girl rang the doorbell and stated there is an old man sitting on the bench, and she was going to call the police. Police arrived, explained to her this resident was discharged from the facility, he left the hospital AMA, and we have no idea how her got back here and on the bench. Police left with resident. [sic]</p> <p>During an interview on 6/5/24 at 8:00 a.m., staff member A stated he was notified by staff member C resident #1 requested reentry after leaving an acute hospital against medical advice in the early morning hours on 5/23/24. Staff member A stated staff member D refused to allow resident #1 into the facility because she did not have provider readmission orders. Staff member A stated, in hindsight he should have reported the facility event, to the state reporting system.</p> <p>2. Review of the following facility reported incidents showed late reporting to the State Survey Agency:</p> <p>a. Review of a facility reported incident showed an allegation of a fall with injury for resident #11. This allegation occurred on 1/19/24 and was reported to the State Survey Agency on 1/19/24. The facility's investigation and findings were not reported to the State Survey Agency until 2/12/24. There were 23 days between the submission of the allegation, and the submission of the final investigation.</p> <p>b. Review of a facility reported incident showed an allegation of resident-to-resident abuse for resident #2 and resident #13. This allegation occurred on 1/19/24 and was reported to the State Survey Agency on 1/19/24. The facility's investigation and findings were not reported to the State Survey Agency until 2/12/24. There were 23 days between the submission of the allegation, and the submission of the final investigation.</p> <p>During an interview on 6/5/24 at 8:00 a.m., staff member A said the prior administrator's last day of work was on 1/19/24. Staff member A started employment on 1/22/24. Due to the change in position, a miscommunication had occurred, and staff member A did not realize the findings were not submitted for resident #11 and #13. Facility findings were reported to the State Survey Agency on 2/12/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Billings Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 S 27th St Billings, MT 59101	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Review of a facility reported incident showed an allegation of injury of unknown origin for resident #12. This allegation occurred on 3/3/24 and was reported to the State Survey Agency on 3/3/24. The facility's investigation and findings were not reported to the State Survey Agency until 3/13/24. There were nine days between the submission of the allegation, and the submission of the final investigation.</p> <p>d. Review of a facility reported incident showed an allegation of resident-to-resident abuse for resident #6 and resident #14. This allegation occurred on 4/26/24 and was reported to the State Survey Agency on 4/26/24. The facility's investigation and findings were not reported to the State Survey Agency until 5/3/24. There were six days between the submission of the allegation, and the submission of the final investigation.</p> <p>e. Review of a facility reported incident showed an allegation of staff-to-resident abuse for resident #10. This allegation occurred on 5/3/24 and was reported to the State Survey Agency on 5/3/24. The facility's investigation and findings were not reported to the State Survey Agency until 5/10/24. There were six days between the submission of the allegation, and the submission of the final investigation.</p> <p>f. Review of a facility reported incident showed an allegation of resident-to-resident abuse for resident #5 and resident #11. This allegation occurred on 5/10/24 and was reported to the State Survey Agency on 5/10/24. The facility's investigation and findings were not reported to the State Survey Agency until 5/16/24. There were five days between the submission of the allegation, and the submission of the final investigation.</p> <p>g. Review of a facility reported incident showed an allegation of a fall with injury for resident #3. This allegation occurred on 5/11/24 and was reported to the State Survey Agency on 5/11/24. The facility's investigation and findings were not reported to the State Survey Agency until 6/3/24. There were 22 days between the submission of the allegation, and the submission of the final investigation.</p> <p>h. Review of a facility reported incident showed an allegation of a fall with injury for resident #9. This allegation occurred on 5/18/24 and was reported to the State Survey Agency on 5/21/24. The facility's investigation and findings were not reported to the State Survey Agency until 6/3/24. There were 14 days between the submission of the allegation, and the submission of the final investigation.</p> <p>i. Review of a facility reported incident showed an allegation of a fall with injury for resident #8. This allegation occurred on 5/21/24 and was reported to the State Survey Agency on 5/21/24. The facility's investigation and findings were not reported to the State Survey Agency until 6/3/24. There were 12 days between the submission of the allegation, and the submission of the final investigation.</p> <p>During an interview on 6/5/24 at 6:15 p.m., staff member B stated the facility administrator submits facility reported events to the state bounds reporting system. Staff member B stated in the administrator's absence it is the responsibility of the director of nursing to submit facility events to the state Bounds reporting system. Staff member B stated, I dropped the ball, and it was my responsibility to report and investigate facility events when the administrator was absent.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Billings Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 S 27th St Billings, MT 59101	

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy titled, Abuse Policy, last revision dated 6/14/23, showed:</p> <ol style="list-style-type: none"> .1. Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, shall conduct an investigation of the alleged incident. 2. The Administrator or designee shall interview any staff members, residents, family members or any others who may have knowledge of the incident. 3. The Administrator or designee shall report the results of all investigations to the State Survey Agency within 5 working days of the incident and other agencies as required by state law or regulation. If the alleged violation is substantiated, appropriate corrective action will be taken . [sic]