

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  09/12/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>51133</p> <p>Based on interview and record review, the facility failed to provided pain medication as ordered to relieve chronic pain, this failure caused the resident to voice pain, for 1 (#69) of 3 sampled residents. Findings include:</p> <p>A review of a Facility Reported Incident, dated 8/6/24, showed an allegation of neglect concerning pain medication administration. The report showed NF2 failed to medicate one resident for pain (#69) on 8/6/24. The facility's investigation showed NF2 reported she had forgotten to give the medication.</p> <p>Review of resident #69's MAR, dated August of 2024, showed the following order, HYDROcodone-Acetaminophen Oral Tablet 7.5 - 325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth five times a day related to OTHER CHRONIC PAIN (G89.29) Hold if sedated or SBP &lt;90. Order Date- 7/26/2024 1131 (11:31 a.m.) [sic] The resident's MAR showed the 1:00 a.m. hydrocodone-acetaminophen dose on 8/6/24 was held. The 5:00 a.m. dose of hydrocodone-acetaminophen on 8/6/24 was not administered as scheduled.</p> <p>Review of resident #69's progress notes, dated 8/6/24, failed to show the reasons why the 1:00 a.m. and 5:00 a.m. doses were held or not given.</p> <p>During an interview on 9/12/24 at 9:53 a.m., resident #69 stated she was in a lot of pain due to missing the 1:00 a.m. and 5:00 a.m. doses on 8/6/24.</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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