STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Billings Rehabilitation and Nursing LLC	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48262 Based on observation, interview, and record review, a facility staff member failed to communicate the location of a resident, when the resident was dropped off for an appointment at the dialysis center and left in the bathroom unattended, and the resident was cognitivey impaired, and elopement risk, and unable to assist himself out of dangerous situations. The resident later located in the bathroom and missed his dialysis appointment, for 1 (#1) of 7 sampled residents transported by facility staff for offsite medical appointments. Findings include: Review of a Facility Reported Incident, sent to the State Survey Agency for resident #1, dated 11/1/24, showed on 11/1/24, at 6:30 a.m., Resident #1 was transported by the facility's transportation driver to a scheduled dialysis appointment. Upon arriving at the dialysis center, the resident urgently requested to use the bathroom. The driver rang the doorbell three times to gain access and was eventually buzzed in by a medical staff. Once inside, the driver assisted the resident to the bathroom, closed the door behind him, and then left the facility. The transportation driver departed the dialysis center without verifying resident #1 was properly attended to, resulting in the resident's oversight for safety. On 11/1/24 at approximately 10:30 a.m., a dialysis center staff member heard resident #1 calling for help from the bathroom. The resident was discovered in the bathroom, needing assistance to maneuver his wheelchair out. Staff member A was informed of the incident and promptly went to the dialysis center and spoke with staff to confirm the details of the event. Resident #1 appeared calm and was transported back to the facility without any reported injuries. However, the dialysis center was unable to complete the resident's scheduled treatment due to a lack of available medical chairs. Resident #1's was seen and examined by the facility's medical provider, who determined resident #1 required further evaluation. Resident #1 was transported to an acute hospital on 11/1/24 and was found to have an inner ear infection, which was not related to the event. The resident was treated with antibiotic therapy and received hemodialysis during his acute stay. Resident #1 was transferred back to the nursing home on 11/6/24. During an observation of the offsite dialysis center on 11/20/24 at 1:10 p.m., a video doorbell was observed at the entrance to the building. (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

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 11/21/2024
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 1:23 p.m., NF2 stated the dialysis center's receptionist was available at 8:30 a.m., and if a resident came to the facility prior to 8:30 a.m., they would have to press the doorbell on the outside of the building. NF2 stated the medical staff who worked on the medical unit would identify who was at the door, using the camera doorbell, prior to the resident gaining access into the building. NF2 stated she had not reviewed the doorbell camera footage from 11/1/24. NF2 stated she would review the camera footage and report whether medical staff unlocked the facility doors on 11/1/24 for resident #1 to access the building. During an interview on 11/20/24 at 3:28 p.m., NF4 stated she transported resident #1 to a medical appointment on 11/1/24 at 6:30 a.m. NF4 stated when she arrived with the resident at the medical facility (dialysis center) the door was locked, so she pressed the doorbell three times, and the front door opened. NF4 stated she assisted resident #1 into the building by pushing his wheelchair. NF4 stated resident #1 expressed he needed to use the restroom, so she proceeded to wheel the resident into the bathroom. NF4 stated she did not help the resident transfer out of his wheelchair because she did not have the required training. NF4 stated resident #1 said he was fine, so she proceeded to close the bathroom door and exit the building. NF4 stated she thought medical staff knew the resident was in the building because they unlocked the door and viewed resident #1 on camera. During an interview on 11/20/24 at 3:53 p.m., NF2 stated she reviewed the camera footage from the video doorbell on 11/1/24. NF2 stated the transportation driver pressed the doorbell three times on 11/1/24 at 6:32 a.m. with the resident sitting in his wheelchair. Medical staff then unlocked the door via computer for the resident to gain access into the building. NF2 stated three staff then presented to the lobby on 11/1/24 at 6:35 a.m. to take the resident back to the medical unit. When the three staff arrived no one was present in the lobby and staff did not check the bathrooms. During an interview on 11/21/24 at 7:54 a.m., staff member E said she would not leave resident #1 unattended at the dialysis clinic if she had transported the resident. During an interview on 11/21/24 at 9:04 a.m., staff member C stated resident #1 requires supervision when going to appointments. Staff member C stated resident #1 had a low BIMS score, with a cognitive deficit with disorganized thoughts at times. Review of resident #1's care plan showed, . Focus - I am a vulnerable adult and have altered cognition and poor safety awareness . . Focus - I am Risk of Elopement due to dementia . . Interventions - I need supervision to limited assist with transfers and in transport to areas of destination. . Focus - Safety/Vulnerability: I cannot reliably recognize a dangerous situation: I may be limited in my interpretation of a dangerous situation . I cannot remove myself to safety in a dangerous situation . [sic] Review of resident #1's Quarterly MDS, with an ARD of 10/31/24, showed the resident had a BIMS of five; severely impaired.