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	06/19/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to prevent and protect 4 residents (#s 7, 8, 11, and 13) from abuse, and failed to sufficiently monitor #8 when grabbing or intruding on the space of other residents. Resident #8's behavior preempted altercations with #13 when he tried to push or remove #8 from his room. Both resident #8 and #13 sustained injuries in the altercations or when falling during the fighting. The 4 residents identified were out of 6 sampled residents reviewed for resident to resident altercations. Findings include: a. Review of an incident reported to the State Survey Agency, dated 6/2/25 at 3:30 p.m., showed resident #8 approached resident #7 in a common area located near the nursing station. Resident #8 grabbed resident #7 by the back of his shirt, pulled him up and out of his (resident #7's) wheelchair, which resulted in both residents falling to the ground. The report showed resident #7 was not exhibiting any behaviors to provoke the physical interaction. The two residents were separated, and resident #8 was placed on enhanced monitoring for future prevention of altercations. Staff member F was not available for an interview and worked on 6/2/25. Resident #7 was unavailable for an interview, and resident #8 was no longer a resident at the facility. b. Review of an incident reported to the State Survey Agency reporting portal, dated 6/2/25 at 5:45 p.m., showed resident #8 entered resident #13's room and initiated a physical altercation with resident #13. The report showed the residents were separated, and resident #8 was placed on one-to-one supervision for future prevention and protection of other residents. The report showed resident #13 stated resident #8 entered his room, uninvited, and approached resident #13's roommate. When the resident's roommate yelled for help, resident #13 intervened, and pushed #8 to the floor. Resident #8 then got up and left the room. The report showed there were no other witnesses, and video surveillance failed to corroborate what resident #13 reported. The report showed resident #8 remained on one-to-one supervision for behavioral monitoring. During an interview on 6/18/25 at 9:15 a.m., resident #13 stated resident #8 entered the room he shared with another resident and approached the roommate. When the roommate yelled for help, resident #13 intervened. Resident #13 stated, I got him (resident #8) out of here. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/19/25 at 8:35 a.m., staff member B stated she started working at the facility in April of 2025 and worked the night shift on 6/2/25. Staff member B stated she was not resident #8's primary caregiver, but stated she had seen the resident around the nursing station, and the resident was being supervised by his primary nurse. Staff member B stated they were waiting for law enforcement to arrive in response to the provider's order to transfer resident #8 to the emergency department for a medical and psychiatric evaluation. c. Review of an incident reported to the State Survey Agency, dated 6/2/25 at 11:30 p.m., after being put to bed, resident #8 got up and entered the room shared by resident #11 and #13. Resident #13 physically pushed resident #8 out of the room, and this occurred after #13 asked #8 to leave the room. During the physical altercation, resident #13 sustained a laceration near his left eye. The residents were separated, and then resident #8 was transferred to the emergency department for further evaluation. During an interview on 6/18/25 at 9:15 a.m., resident #13 stated when resident #8 entered the room he shared with resident #11, he was frustrated at resident #8 because he would not stay out of their room. Resident #13 stated he, and resident #8, were in a physical altercation, resulting in him hitting his head, and he had a laceration and bruising around his left eye. He stated he was punched in the chest multiple times during the altercation. Resident #13 had pictures of his face and chest which showed bruising to both areas. Resident #13 also lifted up his shirt and showed bruising on his right and left chest areas, which was yellowing. Resident #13 stated the left eye injury happened when he fell to the floor, and the chest bruising was from punches thrown by resident #8 when the two were fighting. During an interview on 6/19/25 at 8:35 a.m., staff member B stated when resident #8 was put to bed at approximately 10:45 p.m., he was no longer on one-to-one supervision. Staff member B stated she believed the CNA assigned to be the one-to-one monitor for #8 was in another room assisting a resident. Staff member B stated she thought the CNA probably did not know resident #8 had been put to bed and was no longer being supervised. This lack of one-to-one supervision allowed resident #8 being able to get up out of bed and wheel himself to the room shared by resident #11 and #13. Staff member B stated she observed resident #8 and #13 entangled on the floor in the hallway. Staff member B stated both residents were bleeding, and staff had to separate them when fighting. Staff member B stated resident #8 was then transferred to the emergency department. During an interview on 6/19/25 at 8:55 a.m., when asked about the level of supervision needed to prevent resident #8 from having physical altercations with other residents, staff member A stated the resident had been on one-to-one supervision while he was awake. Staff member A stated the same level of supervision was not necessary when the resident was in bed. Staff member A stated he felt the altercation between resident #8 and resident #13 was mutual, even though resident #8 was in resident #13's room, uninvited, and it was the second time on 6/2/25. Review of the facility's policy titled, Abuse, Neglect and Exploitation, last review date 4/11/25, showed prevention of abuse and neglect included establishing a safe environment by identifying, correcting, and intervening in situations in which abuse and neglect is more likely to occur. The policy also showed the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which may lead to conflict. The policy showed the facility will make efforts to ensure all residents are protected from physical and psychosocial harm by increased supervision of the alleged aggressor.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure medications were given on time, no more than one hour before or one hour after the administration time, for 4 (#s 4, 15, 16, and 19); and failed to give the right medication to the right resident for 2 (#s 15 and 16) of 4 residents sampled for appropriate medication administration. Findings include: 1. During an interview on 6/18/25 at 8:55 a.m., resident #19 stated she has gotten her evening medications late several times. Resident #19 stated the late medications usually happened on weekends and night shift. Review of resident #10's Medication Admin Audit Report, dated 6/15/25, 6/16/25, and 6/17/25, showed the following times the medications were scheduled, and then the documented times they were actually administered: - 6/14/25 at midnight, buprenorphine-narcan 2-0.5 mg given at 1:45 a.m., - 6/14/25 at 6:00 p.m., lidocaine external patch given at 9:00 p.m., - 6/14/25 at 7:00 p.m., Cymbalta 60 mg given at 9:10 p.m., - 6/14/25 at 7:00 p.m., insulin aspart 3 units given at 9:13 p.m., - 6/15/25 at midnight, buprenorphine-narcan 2-0.5 mg not given, - 6/15/25 at 6:00 a.m., lidocaine external patch given at 8:49 a.m., - 6/15/25 at 7:00 a.m., Cymbalta 60 mg, given at 8:49 a.m., - 6/15/25 at 7:00 a.m., insulin aspart 6 units, given at 8:49 a.m., - 6/15/25 at 6:00 p.m., lidocaine external patch given at 5:56 a.m. on 6/16/25, - 6/16/25 at 6:00 a.m., lidocaine external patch, given at 7:34 a.m., - 6/16/25 at 6:00 p.m., lidocaine external patch, given at 5:00 a.m. on 6/17/25, - 6/16/25 at 6:00 p.m., Cymbalta 60 mg given at 2:19 a.m. on 6/17/25 - 6/16/25 at 7:00 p.m., insulin aspart 2 units given at 2:19 a.m. on 6/17/25, - 6/16/25 at 8:00 p.m., melatonin 3 mg given at 2:21 a.m. on 6/17/25, - 6/16/25 at 8:00 p.m., magnesium oxide 400 mg given at 2:21 a.m. on 6/17/25, - 6/16/25 at 8:00 p.m., docusate calcium two capsules given at 2:21 a.m. on 6/17/25, - 6/16/25 at 8:00 p.m., gabapentin 800 mg given at 2:21 a.m. on 6/17/25, (continued on next page)

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Billings Rehabilitation and Nursing LLC	600 S 27th St Billings, MT 59101

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/16/25 at 9:00 p.m., diclofenac sodium external gel 1% given 2:21 a.m. on 6/17/25, and - 6/16/25 at 10:00 p.m., chlorhexidine gluconate 15 ml, given at 5:00 a.m. on 6/17/25. 2. During an interview on 6/18/25 at 9:10 a.m., resident #4 stated she sometimes got her medications late, usually on the night shift. Review of resident #4's Medication Admin Audit Report, dated 6/14/25 and 6/15/25, showed the following times the medications were scheduled, and then the documented times they were actually administered: - 6/14/25 at 6:00 p.m., glatiramer acetate 20mg/ml 1 ml given at 10:37 p.m., - 6/14/25 at 7:00 p.m., sennosides-docusate sodium 8.6-50 mg given at 10:23 p.m., - 6/14/25 at 7:00 p.m., Seroquel 100 mg given at 10:24 p.m., - 6/14/25 at 7:00 p.m., gabapentin 300 mg given at 10:25 p.m., - 6/14/25 at 7:00 p.m., Refresh Tears given at 10:25 p.m., - 6/14/25 at 7:00 p.m., trazodone 50 mg given at 10:30 p.m. - 6/14/25 at 8:00 p.m., Miralax 17 gm given at 10:20 p.m., - 6/14/25 at 8:00 p.m., melatonin 3 mg given at10:22 p.m., - 6/14/25 at 8:00 p.m., baclofen 10 mg given at 10:23 p.m., - 6/14/25 at 8:00 p.m., metformin 500 mg given at 10:23 p.m., - 6/15/25 at 7:00 a.m., folic acid 1 mg given at 10:09 a.m., - 6/15/25 at 7:00 a.m., cholecalciferol 2000 units given at 10:09 a.m., - 6/15/25 at 7:00 a.m., bisacodyl 5 mg given at 10:09 a.m., - 6/15/25 at 7:00 a.m., Refresh Tears given at 10:09 a.m., - 6/15/25 at 7:00 a.m., multiple vitamin one tablet given at 10:09 a.m., - 6/15/25 at 7:00 a.m., empagliflozin 10 mg given at 10:09 a.m., - 6/15/25 at 8:00 a.m., venlafaxine 75 mg given at 10:09 a.m., - 6/15/25 at 8:00 a.m., baclofen 10 mg given at 10:09 a.m., - 6/15/25 at 8:00 a.m., metformin 500 mg given at 10:09 a.m., (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/15/25 at 6:00 p.m., glatiramer acetated 20 mg/ml 1 ml given at 7:40 p.m., - 6/16/25 at 7:00 a.m., folic acid 1 mg given at 8:27 a.m., - 6/16/25 at 7:00 a.m., Refresh Tears given at 8:27 a.m., - 6/16/25 at 7:00 a.m., empagliflozin 10 mg given at 8:27 a.m., - 6/16/25 at 7:00 a.m., multiple vitamin one tablet given at 8:27 a.m., - 6/16/25 at 7:00 a.m., bidacodyl 5 mg given at 8:28 a.m., - 6/16/25 at 7:00 a.m., cholecalciferol 2000 units given at 8:28 a.m., and - 6/16/25 at 11:00 a.m., Refresh Tears given at 12:30 p.m. 3. Review of resident 16's Medication Admin Audit Report, dated 5/15/25 and 5/16/25, showed the following times the medications were scheduled, and then the documented times they were actually administered: - 5/15/25 at 7:00 p.m., Seroquel 400 mg given at 10:18 p.m., - 5/15/25 at 7:00 p.m., Lyrica 100 mg given at 10:18 p.m., - 5/15/25 at 9:00 p.m., acetaminophen 1000 mg given at 10:17 p.m., - 5/15/25 at 9:00 p.m., oxycodone 10 mg given at 10:17 p.m., - 5/15/25 at 9:00 p.m., hydroxyzine HCl 25 mg given at 10:35 p.m., - 5/16/25 at 7:00 a.m., pantoprazole 40 mg given at 9:53 a.m., - 5/16/25 at 7:00 a.m., Cymbalta 60 mg given at 9:53 a.m., - 5/16/25 at 7:00 a.m., Lyrica 100 mg given at 9:53 a.m., - 5/16/25 at 7:00 a.m., amlodipine 5 mg given at 9:53 a.m. - 5/16/25 at 7:00 a.m., Mounjaro 5 mg given at 9:52 a.m.; and, - 5/16/25 at 2:00 p.m., acetaminophen 1000 mg given at 3:20 p.m. Review of resident #16's Nursing Progress Note, dated 5/16/25, showed resident #16 was inadvertently given resident #15's evening (for 5/15/25) medications, which included melatonin 6 mg, memantine 10 mg, tamsulosin 0.4 mg, and trazodone 100 mg. These medications were given in addition to resident #15's regular evening medications. The note showed resident #16 stated he was very sleepy and slept late on 5/16/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of resident #15's Medication Admin Audit Report, dateed 5/15/25 and 5/16/25, showed the following times the medications were scheduled, and then the documented times they were actually administered: - 5/15/25 at 6:00 p.m., lidocaine external patch given at 10:21 p.m., - 5/15/25 at 6:00 p.m., diclopfenac sodium 1% gel given at 10:21 p.m., - 5/15/25 at 7:00 p.m., calcium-vitamin D 500-5 mg-mcg two tablets given at 10:21 p.m., - 5/15/25 at 7:00 p.m., zinc oxide external past 20% given at 10:23 p.m., - 5/15/25 at 7:00 p.m., donepezil HCl 5 mg given at 10:21 p.m., - 5/15/25 at 7:00 p.m., carvedilol 3.125 mg given at 10:27 p.m., - 5/15/25 at 8:00 p.m., atorvastatin calcium 20 mg given at 10:27 p.m., - 5/15/25 at 8:00 p.m., acetaminophen 650 mg given at 1:42 a.m. on 5/16/25, - 5/16/25 at 6:00 a.m., lidocaine external patch 5 % given at 12:30 p.m., - 5/16/25 at 7:00 a.m., zinc oxide 20 % past given at 8:38 a.m., - 5/16/25 at 7:00 a.m., ferrous gluconate 324 mg given at 12:30 p.m., - 5/16/25 at 7:00 a.m., cholecalciferol 3000 units given at 12:30 p.m. - 5/16/25 at 7:00 a.m., Cymbalta 30 mg given at 12:30 p.m., - 5/16/25 at 7:00 a.m., furosemide 20 mg given at 12:30 p.m., - 5/16/25 at 7:00 a.m., multiple vitamin one tablet given at 12:30 p.m., - 5/16/25 at 7:00 a.m., calcium-vitamin D 500-5 mg-mcg given at 12:30 p.m., - 5/16/25 at 7:00 a.m., cetirizine HCl 10 mg given at 12:30 p.m., - 5/16/25 at 7:00 a.m., chewable aspirin 81 mg given at 12:31 p.m., - 5/16/25 at 7:00 a.m., carvedilol 3.125 mg given at 1:40 p.m., - 5/16/25 at 9:00 a.m., acetaminophen 650 mg given at 12:30 p.m., and - 5/16/25 at 9:00 a.m., diclofenac socium 1% gel given at 12:31 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #15's nursing progress notes, dated 5/15/25 and 5/16/25, failed to show if the resident was given the correct doses of the medications (melatonin, memantine, tamsulosin, trazodone), inadvertantly given to resident #16, on 5/15/25. Review of the facility's policy titled, Medication Administration, last review date 4/11/25, showed, . Ensure that the six rights of medication administration are followed: a. Right resident .e. Right time, f. Right documentation . and, . Administer within 60 minutes prior to or after scheduled time . Review of the facility's policy titled, Medication Errors, last review date 4/11/25, showed medication administration is performed in accordance with accepted standards of practice. The policy showed once a medication error was identified, the error will be evaluated to determine if it was a significant error or not. utilizing three general guidelines: - a. Resident's Condition, - b. Drug Category, and - c. Frequency of Error

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain an accurate and complete medical record for 3 (#s 7, 8, and 13) of 21 sampled residents. Findings include: 1. Review of a Facility-Reported Incident, dated 6/2/25 at 3:30 p.m., and submitted to the State Survey Agency reporting portal, showed an altercation which involved resident #7 and resident #8. The report showed resident #8 approached resident #7 from behind and pulled him up and out of his wheelchair, causing both resident #7 and the wheelchair to tip over and fall to the floor. The report showed resident #7, . was not engaging in any distress [sic] behaviors at the time, but was saying 'help' calmly and repetitively, a known behavioral baseline. Review of resident #7's nursing progress notes, dated 6/2/25, failed to show the incident described above. The resident's medical record progress notes failed to show documentation of an assessment of resident #7's physical and psychosocial condition after the incident. Review of resident #8's nursing progress notes, dated 6/2/25, failed to show the incident between resident #7 and resident #8. The notes failed to show documentation of what interventions were implemented to protect #7, or others, and resident #8's response to these interventions. Resident #7 was out of the facility during most of the survey and unavailable for an interview. 2. Review of a Facility-Reported Incident, dated 6/2/25 at 5:45 p.m., and submitted to the State Survey Agency reporting portal, showed a physical altercation between resident #8 (aggressor) and resident #s 11 and 13 (victims). The report showed both resident #11 and resident #13, . reported that [Resident #8] entered their shared room and initiated a physical altercation. Review of resident #13's nursing progress notes, dated 6/2/25, failed to show a description of the incident or the resident's physical and psychosocial condition after the incident. Review of resident #8's nursing progress notes, dated 6/2/25 at 6:13 p.m., showed the provider was notified of two altercations involving resident #8 within three hours. The note showed the provider ordered the resident be sent to the emergency department for an evaluation. 3. Review of a Facility-Reported Incident, dated 6/2/25 at 11:30 p.m., and submitted to the State Survey Agency reporting portal, showed a physical altercation between resident #8 and resident #13. The report showed after being put to bed and observed sleeping resident #8 left his room and entered the resident #13's room, uninvited. The report showed resident #13 instructed resident #8 to leave, stating he (#13) was, sick of him (#8), and told resident #8 to get out of his room, and an altercation occurred, to include both men falling. Resident #13 sustained injuries during the event and resident #8 was transferred to the emergency department for an evaluation. Review of resident #13's nursing progress notes, dated 6/2/25, failed to show a description of the altercation or the resident's condition after the altercation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #13's nursing progress note, dated 6/3/25 at 10:04 a.m., showed after the resident had an altercation with another resident (not identified), resident #13 had a left forehead laceration measuring 2.0 by 0.2 with no drainage and his left eye was black and blue on the lateral aspect of the eyelid. During an interview on 6/19/25 at 8:35 a.m., staff member B stated each of the residents involved in the altercations should have a note in their medical record which described the incident and their physical and psychosocial condition if applicable. When asked, staff member B was not able to explain why there were no progress notes describing the three altercations involving resident #8. Staff member F worked on 6/2/25, and was assigned to the unit for #8. Staff member F was not available for an interview during the survey.