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	02/26/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations of abuse to the State Survey Agency (SSA) within the required timeframe of an allegation of sexual abuse for 1 (#73); and failed to report the investigative findings for allegations of abuse for 4 (#s 10, 46, 67 and 76) of 25 sampled residents. Findings include:1. Review of resident #73's Behavior Progress Note, dated 12/14/25, showed: Resident has repeatedly been removed from female resident rooms. Resident has also been rubbing legs of other female residents. Resident has been repeatedly corrected by staff and educated on inappropriate behavior. During an interview on 2/24/26 at 4:51 p.m., staff member A stated they were reviewing a former resident's chart (resident #73) who wanted to return to the facility. Upon the review, they noted a progress note which should have been a reportable event, sent to the State Survey Agency, but had not been reported. Staff member A stated they did not know of the incident before the review and would be making a late report to the State Survey Agency regarding the incident. Staff member A stated a staff member noticed resident #73 had his hand on resident #46's thigh while he was assisting the resident to eat. He stated the aide (staff member N) who witnessed the incident and asked the resident to remove his hand from the resident's thigh, which he did, and the aide reported the incident to the nurse on duty (staff member O). Staff member A stated staff member O did not report the incident. He stated the expectation was for staff to report allegations of resident-to-resident abuse or inappropriate contact immediately or within two hours of the incident. During an interview on 2/24/26 at 5:05 p.m., staff member N stated she witnessed resident #73 assisting resident #46 with eating. She stated resident #73 had his hand on resident #46's thigh. She said she did not feel that it was appropriate for resident #73 to have his hand on her thigh, and she asked the resident to keep his hands to himself. Staff member N stated the resident removed his hand from the resident #46's thigh, but he did place his hand again on her thigh. Staff member N stated she asked resident #73 to remove his hand again from resident #46's thigh, which he did. Staff member N stated she did not feel it was appropriate and reported the behavior to the nurse on duty, staff member O. During an interview on 2/25/26 at 11:21 a.m., staff member O stated he was informed by staff member N that resident #73 kept placing his hand on resident #46's thigh while he was assisting her with eating. Staff member O stated he did not observe the behavior but did not feel the behavior was sexual or predatory in nature. He stated he made a note of it in the resident's behavior charting but did not report the incident. He stated he had received Relias training on the different forms of abuse and when and to whom to report any concerns or incidents. 2. Review of a facility reported event dated 1/7/26, showed residents #10 and #76 were involved in (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a verbal altercation. Investigation findings were due to the State Survey Agency on 1/14/26. The facility reported the investigation findings late on 1/15/26. During an interview on 2/25/26 at 2:58 p.m., staff member A stated the facility had an Administrator in Training who was submitting reportable events and investigation findings to the State Survey Agency. Staff member A stated the investigation findings for the facility reported event on 1/7/26 were due on 1/14/26. Staff member A stated the investigation findings were submitted on 1/15/26. Staff member A stated he received alerts when findings were due and reminded the facility of the due dates. Staff member A did not know why the findings were submitted late. 3. Review of a facility reported event, dated 2/2/26, showed that resident #67 reported verbal abuse by a staff member. Investigation findings of the verbal abuse event were due to the State Survey Agency on 2/9/26. The facility reported the investigation findings late on 2/10/26. During an interview on 2/25/26 at 2:58 p.m., staff member A stated the facility had an Administrator in Training who was submitting reportable events and investigation findings to the State Survey Agency. Staff member A stated the investigation findings for the facility reported event on 2/2/26 were due on 2/9/26. Staff member A stated the investigation findings were submitted on 2/10/26. Staff member A did not know why the findings were submitted late. Review of a facility policy titled, Abuse, Neglect, and Exploitation, implemented 4/11/25, showed: . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. . B. The Administrator will follow up with government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to investigate an allegation of resident-to-resident inappropriate nonconsensual contact for 2 (#s 46 and 73) of 25 sampled residents. Findings include:Review of resident #73's Behavior Progress Note, dated 12/14/25, showed: Resident has repeatedly been removed from female resident rooms. Resident has also been rubbing legs of other female residents. Resident has been repeatedly corrected by staff and educated on inappropriate behavior. During an interview on 2/24/26 at 4:51 p.m., staff member A stated they were reviewing a former resident's chart (resident #73) who wanted to return to the facility. Upon the review, they noted a progress note for a reportable event that was not reported or investigated involving residents #'s 46 and 73. Staff member A stated they did not know of the incident before the review and would be sending a late report to the State Survey Agency regarding the incident and conducting an investigation (See F609 for details of allegation). Review of the facility's reported incidents, sent to the State Survey Agency, did not show that the incident between residents #46 and #73 was reported or investigated by the facility for the event on 12/14/25. Review of the facility's policy and procedure titled, Abuse, Neglect, and Exploitation, with an implementation date of 4/11/25, showed: V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation . 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility licensed nursing staff, assigned to complete treatments on a resident's burn, failed to provide services in accordance with professional standards of nursing practice related to wound assessments, treatments, and documentation of the wound details and current status, for 1 (#73) of 25 sampled residents. The failure placed the resident at elevated risk for the delayed identification of complications and or ineffective treatments not being addressed promptly, due to the lack of wound information in the resident's medical record. Findings include:During an interview on 2/24/26 at 11:12 a.m., staff member B stated resident #73 had obtained a burn injury to his lower abdomen, groin, and right hip on 10/30/25, after accidentally spilling hot soup onto himself. The right hip wound was a second-degree burn with blistering, and the lower abdomen and groin were first-degree burns. Staff member B stated wound treatments were initiated on the notification to the provider about the burns, which was on 10/30/25, and the burn treatments were completed as ordered until the wound healed.During an interview on 2/24/26 at 1:34 p.m., staff member G stated that the previous wound management nurse left the facility unexpectedly two weeks earlier. Staff member G stated she was unaware of the resident's wound until that time. Staff member G stated she assessed the wound for the first time on 11/21/25 and noted it had resolved. Staff member G stated a wound's progress (healing) should be assessed routinely by the nurse, who then documents the status and evaluation of the effectiveness of the wound treatments provided. Review of resident #73's nursing progress note, dated 10/30/25 at 2:31 p.m., showed: Resident sustained a burn to right upper thigh, groin, and low abdomen during early morning hours. Burn on thigh is 5 1/2 by 5 inches with a large blister which has since broken and drained serous fluid. The abdomen has several small burns the blistering to this area has resolved. The groin has 2 red areas without blistering. There are 41/2 by 2 3/4 inches and 2 1/4 by 1 1/2 inches. Burns had been covered with loose ABD dressings for protection from rubbing. Provider did evaluate and gave instruction to ADON for new orders. Dressing will be applied as instructed . [sic]Review of resident #73's nursing progress note, dated 11/1/25 at 5:36 a.m., showed: area of burn cleaned and Bacitracin applied- covered with abd- tolerated well-N/S of infection. [sic] Review of resident #73's nursing progress note, dated 11/3/25 at 2:25 a.m., showed: area of burn cleaned and Bacitracin applied- covered with abd- tolerated well-N/S of infection. [sic]Review of resident #73's nursing progress note, dated 11/6/25 at 12:54 a.m., showed: Bacitracin applied as ordered to burn on right hip. Resident tolerated well. Wound bed pink/red in color. No signs of infection. Minimal drainage noted. Dressing applied to area. Scant serous drainage noted. [sic]Review of resident #73's nursing progress note, dated 11/21/25 at 7:09 a.m., showed:Area to right hip checked- no open areas-clean dry and skin is intact-resolved. [sic]Review of resident #73's nursing progress notes failed to show a wound status note on 10/31/25, 11/2/25, 11/5/25, and 11/7/25 through 11/20/25, and the notes that were completed did not address all the areas of the burn(s), the status of the burns, location, classification, measurement, burn assessment, the status of the wound edges, if there was any odor, if the resident had pain or if there were signs of infection, or if the treatment at the time was beneficial or not. Review of resident #73's physician order, dated 10/30/25, showed: Adaptic or Optifoam dressing with daily dressing changes to right lateral hip burn site. One time a day for second degree burn of right lateral hip. Notify provider of any worsening. [sic]Review of resident #73's Medication Administration Record for November 2025 showed the dressing change was not documented as completed on eight out of 21 days.Review of a facility policy titled Wound Treatment Management, dated 4/11/25, showed: . 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record .8. The effectiveness of treatments will be (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitored through ongoing assessment of the wound .Review of a professional standard titled, Principles for Nursing Documentation, published by the American Nurses Association, accessed online on 3/2/26 at https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/ana-principles/, showed: Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice.