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	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record review, the facility failed to ensure the physician was notified of a resident's change in condition of her mental status for 1 (#1) of 17 sampled residents. This deficient practice resulted in resident #1 being discharged from the facility involuntarily on 5/18/26 at 9:50 p.m. for behaviors related to threatening others in the building, to an unsafe environment. Findings include:During an interview on 5/20/26 at 1:48 p.m., staff member O stated resident #1 came to her on 5/16/26 and stated, My roommate needs to be out of my room tonight or something's going to happen. Staff member O stated she did not ask any questions or what the statement meant. Staff member O stated resident #1 asked several times if the roommate would be moved and once the staff moved the roommate to another room, resident #1 repeatedly thanked her. Staff member O stated resident #1 seemed to be happy and pleasant on 5/17/26. Staff member O stated staff member U came to her on 5/18/26 at the start of her shift and reported resident #1 had made a threat to staff saying, I need to be moved, or my roommate needs to move or something physical is going to happen. Staff member O stated she did not ask questions as to what the resident's needs were or what the threat meant. Staff member O stated she did not document the behaviors because she did not know where to document them.During an interview on 5/20/26 at 2:57 p.m., staff member C stated she was alerted of resident #1's violent history via text from a staff member on 5/17/26. Staff member C stated resident #1 could not articulate her needs based on her schizophrenia diagnosis and could only state, I'm feeling agitated. Staff member C stated resident #1 had done the right thing by notifying her nurse that something was triggering her by going to the nurse and saying she wanted to hurt someone. Staff member C stated the facility staff had de-escalated, separated and monitored the situation so the physician was not contacted. Staff member C stated the facility was able to maintain safety and a safe environment. Staff member C stated resident had not had threatening behaviors prior to the evening of 5/16/26. Staff member C stated the facility contacted the psychiatrist on 5/18/26. Staff member C stated she had not considered contacting the physician during behaviors because the facility was not sure the behaviors were a change from her baseline. Staff member C stated she had not considered contacting the physician for a medication addition or adjustment to assist with behaviors (threats to harm others).Review of resident #1's Progress Notes, dated 5/11/26 - 5/19/26 showed resident #1 had a BIMS (Brief Interview for Mental Status) of 9 (moderate cognitive impairment). On 5/16/26 the nurse documented resident #1 had moved to a new room and the roommates seemed to be getting along well. On 5/18/26 the progress note showed resident #1 had stated to the medication aide, if my roommate isn't moved out of my room tonight something bad is going to happen. The progress notes showed resident #1 was grateful when her roommate was moved out and repeatedly thanked the staff. On 5/18/26, the progress note showed resident #1, came to her and stated she needed to change rooms because her roommate was a bitch and was threatening the roommate.Review of the facility policy, Notification of Changes, dated 4/4/26, showed:- . The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.- . Circumstances requiring notification include:- . 2. Significant (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change in resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident who was involuntarily discharged was discharged to a safe environment; and failed to ensure the medical record included physician documentation of the dangers of the resident remaining in the facility would pose, interventions attempted, and efforts to meet resident's needs for 1 (#1) of 17 sampled residents. This deficient practice resulted in resident #1 being discharged to a home with a caregiver who had expressed she was unable to care for resident #1. Findings include:During an interview on 5/20/26 at 12:42 p.m., NF2 stated she was contacted by the facility the evening of 5/18/26, and she was told resident #1 was threatening residents and the facility would be calling the police department and resident #1 could no longer stay at the facility and was being discharged . NF2 stated she told staff member C she would drive over immediately. NF2 stated the facility was already aware of resident #1's violent behaviors in the past and NF2 had told the facility she believed resident #1's medications were off (not as high of doses as she previously took at home). NF2 stated she reminded the facility a tree had fallen on her house and it was not a safe place for resident #1 to discharge to, as the roof was caving in. NF2 stated she was given the choice of resident #1 going to jail or taking resident #1 back home so she took her home to her house. NF2 stated she told the facility she could no longer care for resident #1 when she brought her to the facility on admission on [DATE]. NF2 stated nothing had changed in the week since resident #1 came to the facility and she still could not take care of her. NF2 stated she had not received any notifications of behaviors until the morning of the day resident #1 was discharged . NF2 stated she refused to sign the discharge papers because she did not believe it was right to force resident #1 to leave without notice or threaten resident #1 with calling the police if she did not discharge. NF2 stated resident #1 had not been violent since she quit drinking alcohol four years prior and really felt her behaviors were medication related.During an interview on 5/20/26 at 1:09 p.m., resident #2 stated she was roommates with resident #1 before she left. Resident #2 stated resident #1 never threatened her or was mean or nasty towards her.During an interview on 5/20/26 at 1:15 p.m., resident #3 stated she was roommates with resident #1 and they were friends. Resident #3 stated they had meals together and resident #1 was always nice to her. Resident #3 stated resident #1 moved to a different room because she was too noisy, but they remained friends afterwards. Resident #3 stated resident #1 never threatened her.During an interview on 5/20/26 at 1:19 p.m., staff member C stated resident #1 was discharged because she was making threats about her peers (not anyone specific) to staff member O. Staff member C stated resident #1 stated, If someone doesn't leave me alone or go away, something bad is going to happen. Staff member C stated resident #1 was discharged on 5/18/26.During an interview on 5/20/26 at 1:27 p.m., staff member A stated resident #1 had a history of killing her husband, and a history of parole and making threats. Staff member A stated resident #1 was discharged because she was a danger to other residents. Staff member A stated resident #1 and NF2 did not agree to the involuntary discharge. Staff member A stated resident #1 mentioned her feelings (threats) to the staff and did not mention a specific resident.During an interview on 5/20/26 at 1:48 p.m., staff member O stated resident #1 came to her on 5/16/26 and stated, My roommate needs to be out of my room tonight or something's going to happen. Staff member O stated she did not ask any questions or what the statement meant. Staff member O stated resident #1 asked several times if the roommate would be moved and once the staff moved the roommate to another room, resident #1 repeatedly thanked her. Staff member O stated resident #1 seemed to be happy and pleasant on 5/17/26. Staff member O stated staff member U came to her on 5/18/26 at the start of her shift and reported resident #1 had made a threat to staff saying, I need to be moved, or my roommate needs to move or something physical is going to happen. Staff member O stated she did not ask questions as to what the resident's needs were or what the threat meant. Staff (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member O stated she did not document the behaviors because she did not know where to document them. Staff member O stated she called staff member C, kept the roommates separated, and staff member A arrived at the facility. Staff member O stated she was present during the meeting between staff member A and NF2. Staff member O stated, Unfortunately, after conversations with the staff, we (the facility) are moving forward with discharge. Staff member O stated NF2 was upset and stated, You'll be hearing from our lawyers. This is your plan, not mine. You are using her past against her. Staff member O stated NF2 refused to sign the discharge papers.During an interview on 5/20/26 at 2:57 p.m., staff member C stated she was alerted of resident #1's violent history via text on 5/17/26, from facility staff who had researched her murder case on the internet and sent staff member C a news article. Staff member C stated resident #1 could not articulate her needs based on her schizophrenia diagnosis and could only state, I'm feeling agitated. Staff member C stated resident #1 had done the right thing by notifying her nurses that something was triggering her. Staff member C stated the facility staff had de-escalated, separated and monitored the situation. Staff member C stated the facility was able to maintain safety.During an interview on 5/20/26 at 3:07 p.m., staff member H stated she reached out to resident #1's psychiatrist on 5/18/26 and medication doses were corrected to match doses resident #1 was receiving at home, and face to face was scheduled between the psychiatrist and resident #1.During an interview on 5/20/26 at 3:14 p.m., with staff members A, C, and J, staff member C stated medication changes made by a psychiatrist usually take 14-30 days to take full effect. Staff member A stated he did not offer NF2 the option of an evaluation at the hospital for resident #1. Staff member A stated he told NF2 resident #1 must discharge immediately. Staff member A stated he should have offered NF2 the option of hospital evaluation before discharging resident #1. Staff member C stated when she received staff reports of several threats, it raised her hackles so she escalated the discharge process. Staff member C stated she was not aware of resident #1's criminal history until 5/17/26. Staff member C stated she found out resident #1 had murdered her husband and was charged in 2016 for assaulting NF2 with a knife. Staff member C stated resident #1 had two different roommates, was on 15-minute checks and was discharged . Staff member C stated the facility had not discussed a private room as an intervention for resident #1 and had not used 1:1 staffing as an intervention. Staff member C stated the facility did not have documentation from the physician of the reasons for the need to involuntarily discharge resident #1 because she was a danger to others in the facility. Review of resident #1's Progress Notes, dated 5/11/26 - 5/19/26 showed resident #1 had a BIMS (Brief Interview for Mental Status) of 9 (moderate cognitive impairment). On 5/16/26 the nurse documented resident #1 had moved to a new room and the roommates seemed to be getting along well. On 5/18/26 the progress note showed resident #1 had stated to staff, if my roommate isn't moved out of my room tonight something bad is going to happen. The progress notes indicated resident #1 was grateful when her roommate was moved out and repeatedly thanked staff. On 5/18/26, progress notes indicated resident #1, came to her and stated she needed to change rooms because her roommate was a bitch and was threatening the roommate. On 5/18/26, progress notes showed NF2 refused to sign the notice of discharge form before leaving with the resident. On 5/19/26, progress notes indicated resident #1 had discharged at 9:50 p.m. on 5/18/26 and the on-call physician was notified at 11:10 p.m. On 5/19/26, progress notes indicated a clarification note reflecting, Resident [#1] did not directly threaten roommate, resident [#1] did come to this nurse to inform me of her feelings.Review of resident #1's Notice of discharge, dated 5/18/26, showed resident #1 was being discharged because: The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. The notice stated resident #1 was being discharged without 30-day notice because: The resident poses an immediate danger to the safety of the other individuals in the facility. The notice also stated resident #1 was being discharged , home with friend [NF2]. The resident/resident representative signature line was not signed.Review of resident #1's Care Plan, dated 5/18/26, showed:- Resident #1 admitted on [DATE], and- .Diagnosis: Anxiety disorder, Schizoaffective disorder, Bipolar type, Depression ., - (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Focus: The resident has a potential psychosocial well-being problem r/t anxiety, Dependent behavior, Inability to problem solve, alcohol dependence, history of violent behavior,- Interventions: When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings., - .Focus: Mood & Behavior: History for an alteration in mood or exhibition of behavioral symptoms r/t: Anxiety, Depression, Schizophrenia. Resident may have behaviors that include but are not limited to irritability, agitation, anxiousness, verbal or physical aggression. - Interventions: Administer medications as ordered, Allow resident time to calm down and reapproach at a later time, Evaluate for need and refer to psychological counseling as recommended by physician, interact in an empathetic and supportive manner, monitor and document each behavior event, offer 1:1 interaction as needed, offer psychosocial support as needed., and -Focus: Discharge Planning: [Resident #1] will continue to stay in the facility as a long-term care resident due to the inability to care for self outside of this setting.Review of the facility's policy, Transfer and Discharge, dated 3/20/26, showed: - 9. Non-Emergency Transferor Discharges:- c. In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding the reason for the transfer or discharge will be provided by a physician.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate and implement a baseline care plan for 1 (#1) of 17 sampled residents. This deficient practice resulted in resident #1's needs not being addressed by staff when resident #1 had behaviors. Findings include:Review of resident #1's medical record showed the record lacked a baseline care plan. A comprehensive care plan was initiated on 5/18/26. Resident #1 was admitted on [DATE].During an interview on 5/20/26 at 3:28 p.m., staff member C stated she was not aware resident #1 did not have a baseline care plan. Staff member C stated resident #1 should have a baseline care plan in place. Review of the facility's policy, Baseline Care Plan, dated 4/4/26, showed:- The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.- 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation and interview the facility failed to ensure infection control processes were followed during wound care to promote healing of a pressure wound for 1 (#15) of 3 sampled residents. This deficient practice had the potential to increase the risk of infection in the resident's Stage III pressure wound. Findings include:During an observation and interview on 5/21/26 at 8:56 a.m., with staff member T and NF3, staff member T opened resident #15's brief on the left side. Resident #15 was reported to have a Stage III pressure ulcer to her left buttock. Resident #15 had dried feces on the lower left side of her buttocks and had actively started to have a bowel movement. Staff member T cleaned the feces from resident #15. Staff member T cleansed the Stage III pressure wound with Vaish cleanser, and NF3 applied a dressing. NF3 left the room and staff member T requested staff member Q to assist in positioning resident #15 after the wound care. Staff member T and staff member Q placed the dirty brief back on resident #15 after the dressing change and left the dirty bed pad under resident #15. Staff member T and Q positioned resident #15 and covered her with blankets.During an interview on 5/21/26, at 9:29 a.m., staff member T stated, I wasn't even thinking. We put the dirty brief back on her. We will go back and change her (resident #15). I didn't even think.

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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. Based on observations, interviews, and record review, the facility failed to ensure a resident, who was at risk of elopement, was supervised and doors were secured for 1 (#5) of 5 sampled residents. This deficient practice resulted in resident #5 eloping from the facility overnight, and found by police the next day. Findings include:Review of a facility investigation for resident #5's elopement, dated 4/16/26, showed resident #5 exited the facility unattended on 4/16/26 at approximately 10:00 a.m. Resident #5 was identified as a high risk for elopement, and had a WanderGuard device in place. Resident #5 had a BIMS of 7, indicating severe cognitive impairment. Resident #5 was located on 4/17/26 and transported to the hospital for evaluation. Resident #5 was found to have no injuries.Review of the facility's document, Root Cause Analysis, dated 4/21/26, showed the root cause of the elopement was identified as, failure of a staff member to follow established facility policies and procedures related to elopement prevention, resident supervision, and Wander guard monitoring process. The document showed interventions to include a, full system check of all exit doors and Wander guard systems by the Maintenance Director and Nursing Home Administrator.During an observation on 5/20/26 at 8:32 a.m., with staff member C, several exit doors in the facility were tested and the following was revealed. The hall D exit door was tested, and the alarm was sounding so quietly, it could not be heard. The Activities, no smoking exit door, was not sounding when tested with a WanderGuard. The dining room door did not have a WanderGuard alarm but did have a screamer alarm. When testing the dining room exit door, staff member C found the screamer alarm was turned off.During an interview on 5/20/26 at 9:02 a.m., staff member D stated he and staff member A tested the doors last night (5/19/26) and must have forgotten to turn the alarms back on. Staff member D stated he did not know he should be checking the sound on the alarms. Staff member D stated he would walk down the hall and look for the light on the WanderGuard box on the wall to light up, and considered the lights as the alarm system was working. Staff member D stated he used to check the screamer alarms, but he stopped when the task dropped off his work order system.During an observation and interview on 5/20/26 at 9:08 a.m., staff member C tested resident #12's WanderGuard bracelet with the tester box and the bracelet did not work. Staff member C tested resident #18's bracelet and the bracelet did not work. Staff member C took both residents to the door and the alarms went off. Staff member C stated the tester was not working. Staff member C stated the tester was to be used each shift by the floor staff to check the bracelets. Staff member C stated she had not received any reports of the tester not working but would order a new one immediately.During an observation and interview on 5/20/26 at 8:45 p.m., the dining room doors were closed and lights were off. The doors were not locked, allowing residents to enter. Resident #14 entered the dining room at 9:02 p.m. Resident #14 was in the dining room, in the dark for seven minutes when he walked back out of the dining room. Staff member C noticed resident #14 exiting the dining room and assisted him back to his hall. Staff member C tested the dining room door and found the screamer alarm was off. The door did not have a WanderGuard system box on the wall. When the dining room doors were closed, the screamer alarm could not be heard outside the dining room. Staff member C stated the dining room doors were closed because too many residents were congregating in the dining room at night, leading to behaviors. Staff member C stated she had not considered residents wandering into the dining room and exiting the dining room exit door.During an interview on 5/20/26 at 9:12 p.m., staff member V stated it was confusing trying to keep track of which residents were allowed outside because it was continuously changing.During an interview on 5/20/26 at 11:00 p.m., staff member A stated he decided to lock the dining room doors until a WanderGuard could be applied to the exit door or other arrangements could be made.Review of the facility's policy, Elopements and Wandering Residents, dated 4/30/26, showed:- . This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents .- . 1. The facility is equipped with door locks/alarms to help avoid elopements.