

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/28/2026
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 an allegation of resident abuse in the required timeline for 2 (#s 6 and 8) of 12 residents sampled for timeliness of reporting abuse allegations. Findings include: A review of a Facility-Reported Incident for an event that occurred on 6/25/26 was submitted to the State Survey Agency on 6/26/26 after the administration became aware of a physical altercation between resident #6 and resident #8. The incident's five-day final report was not submitted to the State Survey Agency until 7/4/26, reflecting it was reported late. During an interview on 7/28/26 at 8:00 a.m., staff member A said the initial abuse report was submitted on 6/26/26, as soon as the facility became aware of the physical altercation between resident #6 and #8. Staff member A said the event was investigated, and the final report was completed. Staff member A said the company policy was that all abuse reports must be reviewed and approved by the Regional Operations Director and the Regional Nurse. The final report was sent to the corporate regional staff on 7/3/26. Staff member A said the corporate staff approved the report, so it should have been submitted. Staff member A said he was the person responsible for submitting reports and had no idea why the final report was submitted late.		

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 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 ensure a thorough investigation of a resident-to-resident physical altercation that was completed for 2 (#s 6 and 8) of 12 residents sampled for abuse. This deficient practice could place the residents involved, or others, at risk for abuse, neglect, and negative physical and psychosocial outcomes from abuse. Findings include: A review of a Facility-Reported Incident submitted to the State Survey Agency on 6/26/26 showed resident #s 6 and 8 were in a physical altercation in the activity room. The report showed resident #6 self-reported slapping resident #8 on the evening of 6/25/26. The Facility-Reported incident showed resident #6 had purchased a couch, and the facility staff placed the couch in a common area, where other residents had access to it. Resident #8 had been lying on the couch and was incontinent of urine. Resident #6 became frustrated with resident #8 for soiling her couch and hit resident #8. Although resident #6 slapped #8, the facility did not substantiate abuse. The initial Facility-Reported Incident showed the immediate actions to be taken would be the completion of: Injury Assessments -Skin assessments-Psychosocial assessments-Risk assessments-Dokumentation of a review of behaviors-Care plan reviews and interventions updatedThe Facility-Reported 5-day final report showed the facility would complete:-Nursing Assessments-Psychosocial assessments-Cognitive assessments and- Head-to-toe skin assessmentsReview of resident #6's electronic health records showed the facility did not follow their initial plan as submitted to the State Survey Agency. The facility said resident #6 would have immediate actions of the cognitive assessment, psychosocial assessment, behavior review, care plan updates, a medication review, and a risk assessment. Resident #6's PHQ9 (evaluation for depression) and the BIMS (Brief Interview for Mental Status) were not completed until 7/7/26, four days after the final investigation report was due to the State Survey Agency. Review of resident #6's nursing progress note dated 7/11/26 at 11:47 p.m. showed the facility interdisciplinary review of the resident behaviors included the director of nursing, the social services staff, and the Administrator. The root cause identified for the incident was that resident #6 had a history of generalized anxiety disorder, major depressive disorder, and intellectual disability. The preventative measures put into place included monitoring of the resident's behaviors and documentation of behaviors. Staff were to allow resident #6 to remove herself from situations that were stressful.A review of resident #6's care plan did not include information for the recommended intervention of allowing the resident to remove herself from stressful situations.A review of resident #6's medical record failed to show the facility completed an abuse risk assessment or the identification of the risk she posed to herself or others. Review of resident #8's electronic health record showed the facility did not follow their plan submitted to the State Survey Agency for the Facility-Reported Incident.Review of an interdisciplinary team progress note dated 7/11/26 at 11:35 p.m. showed the team consisted of the director of nursing, social services, and the administrator. The interdisciplinary team reviewed the incident when resident #8 was hit by resident #6. The intervention was to increase the frequency of offering the resident assistance with toileting every two hours. Review of resident #8's electronic health records showed the facility said resident #8 would have the immediate actions of: a cognitive assessment, psychosocial assessment, behavior review, care plan updates, and an abuse risk assessment. Resident #6's PHQ9 (evaluation for depression) was completed 7/23/26, twenty days after the final investigation report was due to the State Survey Agency.Review of resident #8's BIMS (Brief Interview for Mental Status) completed on 5/15/26, which was prior to the altercation with resident #6, but there wasn't one completed after it, as noted by the IDT review.On 7/27/26 at 12:31 p.m., the risk assessments were requested for resident #s 6 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and 8. No risk assessment was received by the end of the survey on 7/28/26. During an interview on 7/28/26 at 8:06 a.m., staff member B said all information the facility had for the abuse allegation was included in the folder which was sent to the State Survey Agency. Staff member B said the PHQ9 would be an assessment that monitors depression and should have been completed between the allegation of abuse and the submission of the final report. Staff member B did not know why the assessments (PHQ9 and BIMS) were not completed right away and not done until after the final report was submitted.		