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	09/12/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51133 Based on observation, interview, and record review, the facility failed to provide a comfortable and homelike environment for 1 (#1) of 24 sampled residents. Findings include: During an interview on 9/11/24 at 10:43 a.m., resident #1 stated she wanted her wall fixed, and she kept telling staff, but they did nothing about it. During an observation on 9/11/24 at 10:51 a.m., there was a horseshoe shaped metal rail which resembled a side rail. The metal rail was attached to the resident's bed and touched the wall. There was an area on the wall which was painted white with tape and measured approximately two feet by one foot. The area had a jagged crack and a large hole in it. A red shelf behind resident #1's headboard had a crack and was broken, which created a large gap on the surface of the shelf. During an interview on 9/11/24 at 11:22 a.m., staff member L stated the maintenance staff was waiting for a room to open up so both of the residents could be moved. The maintenance staff notified nursing, about a month ago, the room would need to be empty in order to complete the repairs to the damaged area(s). Review of the facility document, titled, [Facility Name] Maintenance Request Log, showed the following maintenance request, dated 9/11/24, Wall has hole to be fix, Location, A-8 A-Hall. [sic] The request was not acknowledged or completed on the Maintenance Request Log.

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 09/12/2024
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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41652 Based on interview and record review, the facility failed to provide written notice of the reason for a facility-initiated transfer to a resident or the resident's representative for 2 (#s 4 and 47) of 24 sampled residents. Findings include: 1. Review of resident #4's EHR showed the resident was hospitalized for sepsis and a UTI twice in May of 2024; 5/13/24 to 5/21/24 and 5/24/24 to 5/30/24. The EHR failed to show the required written notice of the reason for the transfers. During an interview on 9/12/24 at 8:27 a.m., staff member E stated someone in administration was responsible for completing the transfer notice when a resident was being transferred. Staff member E stated she was not responsible for completing the written notice when a resident was transferred to a hospital. During an interview on 9/12/24 at 8:35 a.m., staff member F stated she was not aware of any specific form which notified a resident or a resident's representative of the reason for a transfer. A request for resident #4's written notices of transfer were requested on 9/10/24. None were received prior to the end of the survey. 48262 2. Review of resident #47's EHR showed, the resident was transferred to an acute hospital on 8/3/24 after sustaining a fall and hitting his head on the ground. The facility failed to show a Notice of Transfer/Discharge had been provided to the resident or a resident representative, on 8/3/24, at the time the resident was transferred to a hospital. On 9/11/24 at 10:00 a.m., a request was made for a copy of resident #47's Notice of Transfer/Discharge for the 8/3/24 transfer. No records were received from the facility by the end of the survey. During an interview on 9/12/24 at 9:11 a.m., staff member E said a Notice of Transfer/Discharge had not been provided to resident #47 or a family member by the nurse on 8/3/24. Staff member E stated administration was responsible to provide a Notice of Transfer/Discharge to a resident or the resident's representative. Review of the facility policy titled, Discharging/Transferring the Resident, with the last revision date of 12/1/19, showed, . 1. For facility initiated discharges, .the resident advocate (staff member) or designee will provide the resident with a Notice of Discharge/Transfer that explains the reason for discharge (or transfer), the effective date of the discharge, and information regarding how to appeal the discharge if desired.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 41652 Based on interview and record review, the facility failed to provide the required bed hold notice to the resident or the resident's representatives prior to transfer, for 2 (#s 4 and 47) of 24 sampled residents. Findings include: 1. Review of resident #4's EHR showed the resident was hospitalized for sepsis and a UTI twice in May of 2024; 5/13/24 to 5/21/24 and 5/24/24 to 5/30/24. The EHR failed to show the required written bed hold notice. During an interview on 9/12/24 at 8:27 a.m., staff member E stated someone in administration was responsible for completing the bed hold notice when a resident was transferred. Staff member E stated she was not responsible for, nor had she ever completed, the written bed hold notice when a resident was transferred to the hospital. During an interview on 9/12/24 at 8:35 a.m., staff member F stated she was not aware of any specific form associated with the bed hold when a resident was being transferred. A request for resident #4's bed hold notices were requested on 9/10/24. None were received prior to the end of the survey. 48262 2. Review of resident #47's EHR showed, the resident was transferred to an acute hospital on 8/3/24 after sustaining a fall and hitting his head on the ground. The facility failed to show a Notice of Bed Hold had been provided to the resident or the resident's representative, on 8/3/24, at the time the resident was transferred to a hospital. On 9/11/24 at 10:00 a.m., a request was made for a copy of resident #47's Notice of Bed Hold. No records were received from the facility by the end of the survey. During an interview on 9/12/24 at 9:11 a.m., staff member E said a Notice of Bed Hold had not been provided to resident #47 or a family member by the nurse on 8/3/24. Staff member E stated administration was responsible to provide a Notice of Bed Hold to a resident or a resident's representative. Review of the facility policy titled, Holding Bed Space, dated 12/19/16, showed, . Our facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of our bed-hold policy. The policy also showed, . when a resident is transferred for hospitalization . a representative of the business office or designee will provide written information concerning our bed-hold policy.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 48262 Based on interview and record review, facility staff failed to ensure a preadmission screening and resident review document had been completed for 1 (#41) of 24 sampled residents. Findings include: Show you did a RR and there was not a PASARR, and show how long the resident was at the facility. Then you request the document since it wasn't in the record. Did you check other resident records to ensure they had them, and if they did, would the facility systems catch this missing PASARR? A PASARR (Preadmission Screening and Resident Review) document was requested for resident #41 on 9/11/24 at 11:40 a.m. No records were received from the facility by the end of the survey. A review of resident #41's Annual MDS, with an ARD of 7/11/24, showed the resident had a BIMS of 2; severely cognitively impaired. Resident #41's MDS showed the resident had received anti-psychotic, anti-anxiety, and anti-depressant medications during the assessment period. During an interview on 9/12/24 at 8:56 a.m., staff member G said the facility was unable to locate the PASARR for resident #41. Staff member G stated the facility completed a new PASARR for resident #41 on 9/11/24 and submitted the document for review. Staff member G stated resident #41 had transferred from a facility which closed. Staff member G stated the facility at the time was owned by a different company, and the facility did not have access to resident #41's medical records.

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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** 41652 Based on observation, interview, and record review, the facility failed to develop, implement, and document a baseline care plan within 48 hours of admission, for 1 (#57) of 24 sampled residents. The deficient practice placed the resident at risk for adverse outcomes related poor pain control, the need for wound care and dressing changes, and the need for assistance due to her blindness. Findings include: During an observation and interview on 9/9/24 at 3:18 p.m., resident #57 was resting quietly in her bed with the room lights turned off. Resident #57 said she was blind and needed assistance with eating. Resident #57 said she had pain in her legs and needed pain medication to manage it. The resident said she got up for meals. Otherwise, she stayed in bed most of the time. Resident #57 said she had chronic wounds on her legs since she was in her 20's. Review of resident #57's EHR, accessed on 9/9/24, showed the resident was admitted to the facility on [DATE]. The EHR failed to show any documentation of a baseline care plan which should have been completed within 48 hours of admission (by 8/1/24). The baseline care plan would address the immediate care needs of the resident so effective personalized care could be provided by staff, prior to the developement of the comprehensive care plan. During an interview on 9/12/24 at 8:07 a.m., staff member B stated, at the time the resident was admitted , the MDS nurse was responsible for initiating a baseline care plan. Staff member B stated that person no longer worked at the facility. Staff member B stated she could not find a baseline care plan for resident #57 and assumed the MDS nurse had not done it. Staff member B stated the process (for baseline care plans) had been changed, and the nurse completing the admission assessment was now responsible for inititating the baseline care plan.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652 Based on observation, interview, and record review, the facility failed to provide an ongoing program of meaningful activities and one-to-one activities for a resident who was mostly bedridden and blind and failed to develop and implement a comprehensive resident-centered activity care plan, for 1 (#57) of 24 sampled residents. Findings include: During an observation and interview on 9/9/24 at 3:18 p.m., resident #57 was resting quietly in her bed with the room lights turned off. Resident #57 said she was blind and stayed in bed most of the time because of the pain in her legs. When asked what she did to keep herself occupied, resident #57 shrugged her shoulders and was not able to answer. When asked about activities or one-to-one visits, resident #57 said she had not participated in any activities, nor had anyone from the Activities Department talked to her about the available activities. Resident #57 said the only time she was out of her room was she went to the dining room for meals. The resident did not remember anyone from the facility coming to visit her or offering any in-room activities. Review of resident #57's EHR showed the resident was admitted to the facility on [DATE]. The EHR failed to show an assessment of the resident's activity preferences was completed until 9/11/24. The EHR also failed to show the resident was invited to or attended any activities except a single special event on 8/30/24. The EHR also failed to show a care plan which addressed the resident's activity needs. During an interview on 9/12/24 at 8:10 a.m., staff member B stated she talked to the previous Activity Director who said she just forgot to do it (the activity assessment for resident #57). Staff member B stated the current Activity Director was not working and was unavailable to interview. A request for the resident's activity assessment was made on 9/11/24. The facility provided an activity assessment dated [DATE]. The facility was not able to provide an activity assessment done at, or near, the time of admission or after.

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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. 51133 Based on observation, interview, and record review, the facility failed to assist a resident out of bed for meals to prevent aspiration for 1 (#28) of 24 sampled residents, and failed to ensure an equipment storage room that contained a sharp object which resembled a putty knife at the end of A-Hall remained locked. This deficient practice had the potential to cause an avoidable accident for any resident at risk for wandering to entered the unlocked room. Findings include: 1. During an observation on 9/9/24 at 12:40 p.m., the door to the storage room located at the end of A-Hall was unlocked and contained a sharp object which resembled a putty knife on the shelf located to the left of the entrance to the storage room. During an observation on 9/10/24 at 9:25 a.m., the door to the storage room which contained a sharp object resembling a putty knife, located on the shelf to the left of the entrance to the room, was again found unlocked. During an interview on 9/10/24 at 9:57 a.m., staff member K stated the door to the storage room was always locked, and stated, . residents can't get in there. During an interview on 9/11/24 at 11:25 a.m., staff member L stated the door to the storage room was to be locked. During an interview on 9/11/24 at 11:30 a.m., staff member M stated the door to the storage room should be locked because, We have quite a few wandering residents. 51111 2. Review of resident #28's care plan, dated 7/19/24, showed pertinent diagnoses of acquired absence of left leg above knee, weakness, Diabetes Mellitus, and difficulty in walking. During an observation and interview on 9/9/24 at 4:19 p.m., resident #28 was seen lying in bed and a trapeze bar was hanging from the ceiling at the top of the bed. Resident #28 stated staff was to move him with a Hoyer lift from his bed to his chair for meals. The resident said, There isn't time or personnel, for transferring him. The resident stated it would have been comfortable for him to sit in the chair, but, staff doesn't do this. During an interview on 9/11/24 at 2:20 p.m., staff member B stated resident #28 had not been asking to get up for meals into his chair. Staff member B stated she would ask for assistance from physical therapy on what to do for the first time transferring him from his bed to his chair for meals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/11/24 at 4:36 p.m., staff member C stated resident #28 would be having a consult for surgery for a fistula at the end of the week. Staff member C stated resident #28 had not been getting physical therapy for quite a while. Staff member C stated resident #28 did not get transferred from his bed to his chair for meals. Staff member C stated resident #28 had refused in the past when asked to transfer. Staff member C stated she was more concerned with coaching resident #28 to go to his appointment for the fistula surgery consult. Staff member C stated after the surgery consult appointment, staff would address resident #28's concerns regarding physical therapy and transferring. During an interview on 9/12/24 at 11:37 a.m., resident #28's roommate said resident #28 was not being transferred from his bed to his chair for meals. The roommate said it happened, once in a great while when staff ask about it. During an interview on 9/12/24 at 11:40 a.m., staff member N stated staff had not been asking resident #28 to move from his bed to his chair for meals. Staff member N stated this was due to resident #28's refusals and behaviors at times. Staff member N stated resident #28 got upset with staff and had behaviors about moving from his bed to his chair. Staff member N stated staff had not been transferring resident #28 to his chair with a Hoyer lift for about a month. Staff member N stated she was not sure where transfer refusal documentation was being charted by nursing staff. Review of resident #28's Treatment Administration Record, dated August of 2024, showed an order dated 5/25/24, Up to chair for meals with meals for prevention of aspiration pneumonia. [sic] Staff documented this as administered in the August 2024 Treatment Administration Record with scheduled times of 8:00 a.m., 12:00 p.m., and 5:30 p.m. Staff documented the resident refused on the dates of August 3, 7, 11, 12, 13, 17, 18, 21, 22, 26, 27, 30, and 31 of 2024. Review of resident #28's care plan, dated 7/19/24, showed, . Interventions . Staff to use Hoyer lift with two people for transfer. Sit up in chair to eat for all meals to reduce risk for aspirating . The resident is totally dependent on 2 staff for repositioning and turning in bed and as necessary . Staff will monitor for changes in my ability to transfer, move in bed and ambulate.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51111 Based on observation, interview, and record review, the facility failed to implement a comprehensive resident-centered care plan with accurate information about the use of oxygen and BPAP at bedtime for a resident with oxygenation issues, which contributed to the lack of appropriate use of ordered respiratory equipment for 1 (#27) of 24 sampled residents. Findings include: During an observation and interview on 9/11/24 at 9:13 a.m., resident #27 was sitting in his wheelchair, beside his bed. An oxygen concentrator was located near the head of the resident's bed. The oxygen tubing was connected to a bilevel positive airway pressure (BPAP) face mask. Resident #27 stated he wore the BPAP at night, and explained how the concentrator was not working for the last two weeks. Resident #27 stated he wore his BPAP mask at night but the concentrator was on the [NAME] and in the past the concentrator is swapped out when there were issues with it not functioning. During an interview on 9/11/24 at 2:20 p.m., staff member B stated she had not heard about any issues with resident #27's oxygen equipment or BPAP not working correctly. Staff member B stated she, or staff member C, were present when the nursing change of shift report occurred, each morning, and at night. Staff member B stated nothing was reported about resident #27's oxygen equipment to her during the shift change reports she attended. Staff member B stated she worked the previous weekend, and resident #27 did not mention anything to her about his oxygen equipment. Staff member B stated she would check on resident #27's oxygen equipment. During an observation and interview on 9/12/24 at 11:37 a.m., resident #27's oxygen concentrator was observed beside the head of his bed, with the tubing connected to a BPAP face mask. Resident #27 stated staff did not check on his oxygen equipment, or ask about his BPAP or concentrator, yesterday or today. Resident #27 stated the oxygen flow was not working on his oxygen concentrator. Review of resident #27's care plan, with a revision date of 7/8/24, showed, .The resident has shortness of breath . The resident's Pulse Oximetry will remain above (SPECIFY) through the review date. 90% . Interventions: encourage sustained deep breaths by: Using demonstration (emphasizing slow inhalation, holding end inspiration for a few seconds, and passive exhalation), Using incentive spirometer (place close for convenient resident use), Asking resident to yawn. [sic] The record review of #27's care plan showed pertinent diagnoses including: Obstructive Sleep Apnea, Acute Respiratory Failure with Hypoxia, Morbid (Severe) Obesity with Alveolar Hypoventilation. The care plan did not address goals or interventions for the resident's use of oxygen with BPAP at night, or any other precautions related to oxygen use with the need for BPAP. Review of resident #27's Treatment Administration Record, date September of 2024, showed an order dated 6/3/23, . settings are 16/20 cm with 3 LPM oxygen bled in at bedtime for obstructive sleep apnea . Review of a facility policy and procedure, titled, Oxygen Administration, adopted date of December 2016, showed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of this procedure is to provide guidelines for safe oxygen administration. . 2. Review the resident's care plan to assess for any special needs of the resident. . Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis . 2. Signs or symptoms of hypoxia . 3. Signs or symptoms of oxygen toxicity . 4. Applicable vital signs . 5. Lung sounds as appropriate; . 3. Check the tubing connected to the oxygen cylinder to assure that it is free of kinks. . 4. Turn on the oxygen and titrate to the flow rate in accordance with the physician order. . 6. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51133 Based on interview and record review, the facility failed to provided pain medication as ordered to relieve chronic pain, this failure caused the resident to voice pain, for 1 (#69) of 3 sampled residents. Findings include: A review of a Facility Reported Incident, dated 8/6/24, showed an allegation of neglect concerning pain medication administration. The report showed NF2 failed to medicate one resident for pain (#69) on 8/6/24. The facility's investigation showed NF2 reported she had forgotten to give the medication. Review of resident #69's MAR, dated August of 2024, showed the following order, HYDROcodone-Acetaminophen Oral Tablet 7.5 - 325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth five times a day related to OTHER CHRONIC PAIN (G89.29) Hold if sedated or SBP <90. Order Date- 7/26/2024 1131 (11:31 a.m.) [sic] The resident's MAR showed the 1:00 a.m. hydrocodone-acetaminophen dose on 8/6/24 was held. The 5:00 a.m. dose of hydrocodone-acetaminophen on 8/6/24 was not administered as scheduled. Review of resident #69's progress notes, dated 8/6/24, failed to show the reasons why the 1:00 a.m. and 5:00 a.m. doses were held or not given. During an interview on 9/12/24 at 9:53 a.m., resident #69 stated she was in a lot of pain due to missing the 1:00 a.m. and 5:00 a.m. doses on 8/6/24.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 51111 Based on observation, interview, and record review, the dietary staff failed to follow the person-centered dietary preferences for a resident who stated his dietary preferences to dietary staff and had designated preferences listed on his meal slips, for 1 (#50) of 24 sampled residents. Findings include: During an observation and interview on 9/9/24 at 2:51 p.m., resident #50 showed his dietary meal slip from 9/9/24 with standing orders for coffee, milk, and OJ (orange juice) to be served with each meal. The slip displayed his food likes/dislikes, including carrots as a dislike. Resident #50 stated he had to go get his coffee for meals since the staff did not provide the standing ordered coffee with his meals. Resident #50 stated, It seemed like a lot of carrots were served with the meals, although carrots were listed on his food dislikes. Resident #50 stated he told dietary staff that carrots were being served with his meals. Resident #50 stated his likes/dislikes for food preferences were still not followed after he talked to dietary staff about the carrots. Resident #50 stated, it seemed like more (carrots) were served after telling them. During an interview on 9/11/24 at 2:38 p.m., staff member H stated dietary staff followed resident #50's meal slips when placing food items on a tray. Staff member H stated the meal slip standing orders should be served on the tray for the residents. Staff member H stated a resident's meal slip orders and preferences, might be missed when staff is rushing or hurrying when serving. During an interview on 9/12/24 at 11:56 a.m., staff member I stated, It was my bad, I went too fast (when preparing resident #50's tray). He did bring his slip up to me from a meal and asked if I could read what it said about the carrots as a dislike and why they were served to him. Review of resident #50's MAR, dated September of 2024, showed, Regular diet, Regular texture, Regular consistency, per standing orders- may alter diet to accommodate resident's needs. Review of resident #50's Care Plan, review date of 7/28/24, showed, . Provide, serve diet as ordered: Regular w/ regular textures and consistencies. double portions per resident request. The resident can communicate verbally . He does well at communicating his needs and wants . Staff will speak clearly and actively listen during conversations with [resident #50]. Staff will validate communication when needed to ensure messages are clearly understood. [sic]

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 09/12/2024

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 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51111

Based on observation, interview, and record review, the facility failed to consistently, properly date and label open foods, dispose of expired food items, and store and monitor food temperatures in a safe and sanitary manner, for the residents receiving food from the kitchen. Findings include:

During an observation on [DATE] at 11:52 a.m., the kitchen walk-in freezer had items stored on the right side of shelving with large ice chunks on three levels of shelving and the floor. The following undated, unlabeled, and expired food items were found:

- one pork chop (pale grayish white in color) on a tray, covered with clear plastic wrap, dated ,d+[DATE], hardened ice was found inside and outside the plastic wrap, which appeared to be freezer burnt,

- one tray of cod with a use by date of ,d+[DATE],

- one unlabeled food item, which appeared to be soup in a container, with a ripped plastic cover, and a use by date of ,d+[DATE],

- one unlabeled food item which appeared to be a tortilla shell covered in plastic wrap, with a use by date of , d+[DATE],

- one covered container of food labeled 'nanners' [sic] with a use by date of ,d+[DATE],

- one covered container of gluten free pasta with a use by date of ,d+[DATE],

- one bag of unlabeled dough (opened and secured with a knot) with no date,

- one container of yellow cake covered with plastic wrap with a use by date of ,d+[DATE],

- one covered tub of [NAME] sauce dated ,d+[DATE] with an expiration of ,d+[DATE], and

- one package of English muffins (opened and re-sealed) with a use by date of ,d+[DATE].

During an observation on [DATE] at 12:08 p.m., the walk-in refrigerator in the kitchen had the following items stored in it:

- one package of bacon covered in plastic wrap with no date or label on the bottom shelf,

- four trays of bacon covered with parchment paper and stacked on one covered tray of sausage with no dates,

- three margarine spray containers with a best by date of [DATE],

- one bottle of sweet and sour sauce with a smudged and illegible expiration date,

(continued on next page)

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 09/12/2024
NAME OF PROVIDER OR SUPPLIER: Billings Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- one container of apricot preserves, covered with clear plastic wrap, in a container with a use by date of , d+[DATE], - one plastic bag of raisins (opened and re-sealed) with no date when opened and a best before date of [DATE], - one bottle of pineapple juice with a ,d+[DATE] use by date, - one container of frosting covered with clear plastic wrap with a ,d+[DATE] use by date, - one container of cucumber dill salad covered with clear plastic wrap with a [DATE] use by date, - one container labeled fried beans covered with clear plastic wrap use by ,d+[DATE] with an open date of , d+[DATE], and - one container of horseradish covered with clear plastic wrap with a use by date of [DATE]. During an observation on [DATE] at 12:36 p.m., the dry goods storage in the kitchen had the following items stored in it: - one bag of unlabeled white powder in knotted plastic bag with no date, - two unopened bags of raisins with a best by date of [DATE], - one opened box of Oreo cookie crumble pieces with a use by date of [DATE], and - one cardboard box of sweet potatoes with a date of [DATE], with visible mold on the bottom of the box. During an observation and interview on [DATE] at 2:38 p.m., staff member H stated there were daily and weekly checklists of tasks to do for kitchen staff and logs for kitchen audits. Staff member H stated all kitchen staff did food audits for expiration dates. Staff member H stated she was responsible for checking the food expiration dates, for the most part, but I was gone on a honeymoon for two weeks, so I will have to check on some expiration dates. Staff member H stated she educated kitchen staff on labeling and dating food when they put it in the food storage areas. Staff member H stated there was an issue with labels not being removed from the plastic containers when they went through the dishwasher. Staff member H stated kitchen staff was responsible for checking and documenting refrigerator and freezer temperature logs for only those located in the kitchen. Staff member H stated nursing staff was responsible for checking and documenting refrigerator and freezer temperature logs for the two specific resident unit refrigerator and freezers. Staff member H was shown the sweet potato box in the dry storage room with mold on the bottom of the box, with some potatoes left in the bottom of box, which were by the mold. During an observation on [DATE] at 3:18 p.m., the refrigerator next to the central nurses' station had no thermometer to show the temperature was maintained at the proper level. (continued on next page)

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 09/12/2024
NAME OF PROVIDER OR SUPPLIER Billings Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on [DATE] at 11:26 a.m., two thermometers were observed in the freezer at the central nurses' station. There was no thermometer in the refrigerator. Staff member O stated she would check on who is responsible for checking the temperatures for the refrigerator and freezer used for residents, since it was located next to the central nurses' station in a closed room. Staff member O returned with staff member H, who stated to her that, Kitchen staff doesn't check these temps, nursing staff needs to check the two resident unit fridge and freezer temps. Staff member O stated it was good to know now. Review of a facility document labeled, [Facility Name] Refrigerator Log (next to the central nurses' station), for the month of [DATE], with 'Nutrition Room' labeled for Refrigerator section, showed no written temperatures for the refrigerator and freezer on 15 of 31 days during August of 2024. Review of a facility document labeled, [Facility Name] Refrigerator Log (next to the central nurses' station), for the month of [DATE], with 'Nutrition Room' labeled for Refrigerator section, showed no written temperatures for the refrigerator and freezer on four of 11 days in September of 2024. Review of a kitchen audit completed by staff member H, dated [DATE], showed a No in the column labeled Met for, Are there any expired foods and if so, were they disposed of appropriately? with Follow Up Action was expired food so I disposed of it. It showed a No in the column for, Is all food appropriately dated and labeled? with Follow Up Action, no date on opened product threw it away [sic]. Review of a kitchen audit completed by staff member H, dated [DATE], showed a Yes in the column labeled Met for, Are there any expired foods and if so, were they disposed of appropriately? It showed a No in the column for, Is all food appropriately dated and labeled? with Follow Up Action, shakes/shelves not dated. [sic] Review of a kitchen audit for staff member H, dated [DATE], showed a Yes in the column labeled Met for, Are there any expired foods and if so, were they disposed of appropriately? It showed a No in the column for, Is all food appropriately dated and labeled? with Follow Up Action, Working on finding all boxes w/o date. Review of a facility policy titled, Refrigerators and Freezers, adopted [DATE], showed: This facility will ensure safe refrigerator and freezer . temperatures, .and will observe food expiration guidelines. Acceptable temperature ranges are 35 F to 41 F for refrigerators and less than 0 F for freezers . Monthly tracking sheets will include date, temperature, initials of person performing temperature check, and action taken for any out of range temperatures. Food Service Manager or designated employee will check and record refrigerator and freezer temperatures daily. The supervisor will ensure immediate action has been taken if temperatures are out of range. Actions necessary to correct the temperatures will be recorded on the tracking sheet. All food shall be appropriately dated to ensure proper rotation by expiration dates. 'Received' dates (dates of delivery) will be marked on cases and on individual items . 'Use by' dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and 'use by' dates indicated once food is opened . Food service manager will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Food service manager will contact vendors or manufacturers when expiration dates are in question or to decipher codes. [sic]