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	08/14/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure grievances were resolved in a timely manner related to delayed meal service for 3 (#s 18, 51, and 62) of 28 sampled residents. The failure placed the residents at elevated nutritional, psychosocial, and medication management risk. Findings include:1. During an observation and interview on 8/11/25 at 1:56 p.m., resident #18 was observed eating lunch in his room. Resident #18 stated, All the meals have been very late; 2 or more hours sometimes. I have complained, but it doesn't change anything. They just say they don't have enough help in the kitchen.2. During an interview on 8/11/25 at 3:12 p.m., resident #51 stated the meals are late almost all of the time. Resident #51 stated the meal delays have been going on for months.3. During an interview on 8/12/25 at 10:08 a.m., resident #62 stated the meals have been late regardless of where they are served. Resident #62 stated he had complained, stating, Nothing has changed; our meals are still very late and inconsistent. When you complain, you don't hear anything back, and nothing changes. There has to be something they can do. During an interview on 8/11/25 at 3:45 p.m., staff member E stated, I think they are short-handed in the kitchen. The residents complain about the delay and sometimes it's a pretty long wait for them and they are hungry.During an interview on 8/11/25 at 4:12 p.m., staff member A stated the residents, . can eat in the dining room if they want to eat earlier.During an interview on 8/12/25 at 11:10 a.m., staff member C stated the facility's dietary service had been impacted by limited staff, but the facility was able to hire new staff and bring in additional support for meal service. Staff member C stated, We aren't quite there yet, but have made significant improvements . Staff member C stated he was aware of 2-hour late meal observances by surveyors during the survey period.Review of a facility document titled, Grievance Report Form, dated 7/8/25, showed the nature of concerns as follows:Resident is waiting over an hour in the dining room waiting for all meals. There is no consistency .Facility response as follows:Meals have been late . Dietary has been running short staffed.Corrective action:Residents were informed that in 30 days ([DATE]st), meal service will be changed where dinning rooms will be served first and all carts will go out second. This change will help with the wait time in the dinning rooms . More kitchen staff have been hired as well as a dietary manager which will also help with wait times . [sic]Review of a facility document titled, Grievance Report Form, dated 7/15/25, showed the nature of concern as follows: Food Late, want it on time .Facility response as follows:Meal service has been late according to multiple staff and residents . The kitchen has been short-staffed . Because of the short staffing meals have not been ready on time causing delays in when residents are recieving their meals . [sic]Corrective action:Residents have been informed in 30 days ([DATE]st) meal services will change to dinning rooms being served first and halls being served second to help alleviate the wait times for residents who choose to eat in the dinning rooms. Additional dietary staff have also been hired as well as a dietary manager to insure meal times are accurate. [sic]Review of a facility document titled, Grievance Report Form, dated 8/5/25, included the following information: .E-hall didn't eat until 1:45 (yesterday 8-4-2025). Then at dinner time we didn't eat until 6:45 pm . [sic]Facility response as follows: Based off the meal service audit from 8-4-25, meals were late being distributed to everyone . Corrective action:IDT members will continue to monitor and audit the meal services to identify more areas that need improving. On going education with staff will continue. [sic]Review of a facility document titled, Resident and Family Grievances, dated 4/11/25, showed the following: . e. The grievance officer or designee will keep the resident appropriately apprised of progress toward resolution of the grievances. 12. The facility will make prompt efforts to resolve grievances.Review of the posted facility mealtimes showed: breakfast 7:30 a.m., lunch 11:30 a.m., and dinner 5:00 p.m.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide timely notice to the State Long-Term Care Ombudsman of discharge/transfer for 3 (#s 79, 89 & 91) of 28 sampled residents. Findings include:1.During an interview on 8/12/25 at 11:50 a.m., NF1 stated she had not received any transfer or discharge notifications from the facility. During an interview on 8/14/25 at 8:30 a.m., Staff member D stated she was pretty new to this position. She started a year ago and had a quick orientation, and had not known the ombudsman notification was something she needed to do. Staff member D stated she received training from the regional nurse and will now be sending all the notifications of transfer and discharge on the first Wednesday of every month. Staff member D stated the facility now had a process for notification to the ombudsman for transfer and discharge. Review of resident #79's nursing progress notes, dated 6/5/25, showed the resident was transported to the Emergency Department for evaluation. The resident was admitted to the hospital and returned to the facility on 6/14/25. The medical record had not shown evidence the ombudsman was notified of the transfer. 2.During an interview on 8/12/25 at 11:50 a.m., NF1 stated she had previously requested the facility provide notification of discharges, but had not received notification of discharges for several months. During an interview on 8/14/25 at 8:30 a.m., staff member D stated she was previously unaware of the requirement for notification to the State Long-Term Care Ombudsman of facility discharges/transfers. Staff member D stated she had not been providing notification to the State Long-Term Care Ombudsman, but had sent notification “the other day,” of all discharges and transfers for the past 8 months. Review of an e-mail document with subject line, “2025 Transfers and Discharges,” sent from staff member D to NF1, dated 8/12/25 at 5:06 p.m., showed “…here are the last 8 months of transfers and discharges. As discussed I will start sending you all of our transfers and discharges on the first Wednesday of the month for the prior month. If a resident receives a 30-day advance or as soon as practicable discharge I will send you that information at the time the resident receives it…” [sic] 3.Review of resident #89’s chart showed, resident #89 was discharged from the facility on 6/23/25. The chart did not contain evidence that notification was made to the State Long-Term Care Ombudsman. 4.Review of resident #91’s chart showed, resident #91 was discharged from the facility 6/10/25. The chart did not contain evidence that notification was made to the State Long-Term Care Ombudsman.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was supervised to prevent an elopement for 1 (#31) of 28 sampled residents. Resident #31 eloped from the facility without staff knowledge and was found by police in the park across the street from the facility. Findings include: Review of resident #31's reportable incident, dated 7/27/25, showed the resident had walked to the park across from the facility around 3:30 p.m. Staff were notified around 4:15 p.m., by local law enforcement, who stated the resident was seen at the park, and the resident fled when the law enforcement attempted to engage her. The incident report showed the facility administrator was notified at 4:23 p.m. and the resident was located at 4:31 p.m. The incident report showed the resident removed her wander guard, and exited through the main doors. During an interview on 8/14/25 at 9:00 a.m., staff member I stated resident #31 had a high BIMS (Brief Interview for Mental Status) of 13. Staff member I stated the resident took the wander guard off of her ankle by cutting it. Staff member I stated the resident had gotten scissors from another resident to cut the bracelet off her ankle. Staff member I stated the facility staff try to keep her engaged, but the resident can go anywhere she wants because of her high BIMS. Staff member I stated the facility had made referrals to other facilities with locked units. Staff member I stated when the incident happened, they checked all wander guards to ensure they were operating correctly. Staff member I stated the facility was able to see on camera what time the resident left the facility. During an interview on 8/14/25 at 8:45 a.m., staff member F stated resident #31 enjoyed crafts, BINGO, liked to socialize, and listen to music. Staff member F stated the staff are to monitor for exit seeking behavior.During an interview on 8/14/25 at 8:57 a.m., staff member H stated when the incident first occurred, they did 15-minute checks. Staff member H stated the staff try and supervise her every hour on rounds. Staff member H stated the resident was able to get the wander guard off. Review of a facility document titled, Abuse Investigation Interview Summary, dated 7/27/25, showed a phone call was received from a law enforcement agency in which they wanted to know if the facility had a [resident name] living at the facility. Staff member G went and brought the resident back from the park. The resident was assessed and hydrated with liquids with electrolytes. Review of resident #31's MDS, with a ARD date of 7/7/25, did not show that the resident was wearing a wander guard.Review of resident #31's Wander and Elopement Risk Assessment, dated 6/30/25, showed the resident was at risk for elopement and wandering. Because of the results of the Risk Assessment, the facility put a wander guard on the resident. Review of the resident's Wander and Elopement Risk assessment dated [DATE], 3 days after the elopement, showed the resident was at risk for elopement/wandering and had a wander guard. The facility was seeking a locked facility for the resident to transfer to. Review of a written statement dated 7/27/25 at 4:30 p.m., showed staff member G received a phone call from the law enforcement agency. Staff completed an initial search. It was determined the resident was gone for 45 minutes. When the resident returned to the facility she did not have a wander guard. It was determined the resident asked someone else for something to get the wander guard off. A call was placed to the provider and the resident was hydrated. During an interview on 8/14/25 at 9:30 a.m., staff member A stated the residents and staff of the facility were educated to look out for suspicious activities between residents. The corporate office was contacted, and a huddle was performed. Complete assessments were performed, and it was determined the wander guards were functioning and interventions were put in place. A PIP (Performance Improvement Project) for elopement was currently being implemented. Staff member A stated the resident had the ability to understand. Staff member A stated the resident was new to the facility. Staff member A reviewed the video surveillance footage to determine the time frame from the time the resident left to the time the facility was contacted by the law enforcement. Staff member A stated the resident was gone approximately 45 minutes prior to the notification of the facility by law enforcement.Review of the weather history for 7/27/25, the day of the elopement, and time of the elopement showed the temperature was 87 degrees Fahrenheit at 2:53 p.m. and 89 degrees Fahrenheit at 3:53 p.m. There was no information available regarding the traffic on the day and time of the elopement.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure staff performed proper suprapubic catheter care and maintenance for 1 (#35) of 28 sampled residents. This deficient practice resulted in an unidentified and untreated skin breakdown around the resident's suprapubic catheter. Findings include:During an interview and observation on 8/11/25 at 2:38 p.m., resident #35 stated the following regarding his suprapubic catheter: it would leak sometimes and the CNAs only clean around his catheter about every other brief change, he had frequent bladder infections, he had an open wound around his catheter that would get more red and gooey when the CNAs do not tape it to his leg, the staff rarely wear gowns when they clean around his catheter or change his briefs, and the CNAs usually clean his catheter tubing and around the insertion site with alcohol wipes. Resident #35's catheter was noted to not be secured to his leg to prevent pulling.During an interview and observation on 8/12/25 at 7:47 a.m., staff member J stated she was not clear what the actual orders were for what she should use to clean resident #35's catheter and the skin around the insertion site. Resident #35 stated (to staff member J), Just go ahead and use those alcohol wipes over there (pointing to alcohol wipes on a table near his bed). Staff member J used alcohol wipes to clean resident #35's catheter and the skin around the catheter insertion site. Resident #35 was noted to have redness and maceration approximately the size of a nickel around his catheter insertion site. Resident #35 stated, It's usually goopy; this is nothing new. It is usually worse when it's not secured. Staff member J stated she was not sure what to do about the skin redness around resident #35's catheter site. Staff member J did not ensure resident #35's catheter was secured after completing catheter care. During an interview on 8/12/25 at 3:03 p.m., staff member M stated she would document and tell a charge nurse if a resident had redness or skin breakdown around a suprapubic catheter insertion side.During an interview on 8/12/25 at 3:05 p.m., staff member N stated she would let a nurse know if a resident had skin breakdown around a suprapubic catheter insertion site. Staff member N stated she cleaned suprapubic catheters and the insertion sites with cleansing wipes and sprays the facility provides, but never with alcohol swabs.During an interview on 8/12/25 at 3:16 p.m., staff member O stated she did not know about skin redness or maceration around resident #35's suprapubic catheter, nor would she know if a CNA did not report it to her.During an interview on 8/12/25 at 4:35 p.m., staff member P stated she educated all her CNAs to report any skin redness or breakdown to the nurses. Staff member P stated resident #35's orders need to be clarified as to what specifically should be used for cleaning resident #35's suprapubic catheter and insertion site. Staff member P stated if there was skin breakdown around resident #35's suprapubic catheter insertion site, the skin should be protected with a gauze and the catheter should be anchored at all times. Review of a care plan report for resident #35, located in the resident's EHR, date initiated 3/12/25, and authored by staff member Q, showed: . Nurses to perform weekly skin assessments. Notify MD of any new skin impairments and obtain treatment orders as indicated .Review of a care plan report for resident #35, located in the resident's EHR, date initiated 8/6/25, and authored by staff member D, showed: . Staff to use paper tape to secure catheter .Review of a care plan report for resident #35, located in the resident's EHR, date initiated 8/6/25, and authored by staff member B, showed: . Move stat lock weekly from thigh to thigh to prevent skin breakdown. Use skin prep under stat lock .Review of a treatment administration record report for resident #35, located in the resident's EHR, date initiated 8/5/25, showed: . Urinary Catheter: Use paper tape only to secure catheter. Use one layer of wide paper tape to protect skin integrity. Use second layer between lumen to maintain placement. every day shift every Wed for secure catheter . [sic]Review of a facility document, titled, Catheter Care, date implemented 4/11/25, reflected the following: . It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care Both: 24. Document care and report any concerns noted to the nurse on duty For Suprapubic Catheters: . 2. Inspect insertion site for redness, swelling, discharge, or signs of infection . 3. Using a clean cloth or gauze moistened with mild soap and water or facility-approved cleanser (or per orders), gently clean around the insertion site . 4. Use a clean section of cloth or new gauze for each pass . 5. Rinse the area with a separate clean, moistened cloth or gauze to remove any soap residue . 6. Pat the site dry with a clean towel or sterile gauze . 7. Ensure the catheter is secure and not pulling on the insertion site .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to follow up on a re-weigh, document refusals, and implement interventions aimed at addressing a severe weight loss for 1 (#64) of 28 sampled residents. Findings include:Review of resident #64's documented weights showed:-1/3/25 163 lbs.,-2/1/25 162.4 lbs., -3/11/25 163 lbs.,-4/5/25 163.4 lbs.,- May 2025 no weight documented or documented as refused on the treatment administration report or nursing progress notes.-6/1/25 146.6 lbs. This represented a 10.28% severe loss over two months.-July 2025 and August 2025 showed refusals in the resident's treatment administration record.There were no further documented weights.A request was made for resident #64's nutrition notes from February 2025 - current. Review of resident #64's weight change note, dated 6/5/25, showed, RD notes dramatic weight loss. Recommend re-weigh to confirm. There was no follow-up documentation related to the resident's re-weight or further dietary intervention.Review of resident #64's nursing progress note, dated 6/9/25, created 8/12/25, showed, late entry. Resident has not been feeling well and said he would try at a later time.During an interview on 8/13/25 at 9:09 a.m., resident #64 stated it had gotten tough for him to eat since he was so short of breath. Resident #64 started hospice on 8/11/25 for end-stage COPD.During an interview on 8/13/25 at 3:18 p.m., staff member K stated that if they were uncertain about the accuracy of a weight, they would request a re-weight. Staff member K stated the staff needed to be better about showing if a resident had refused to be weighed. Staff member K stated resident #64 had historically been frustrated with the weight conversation and would frequently refuse. He had been on hospice last year, but then discontinued it and his weights had been stable. Staff member K stated resident #64 was not concerned with his weight, and there was an assumption that staff weren't pressuring him because he had been on hospice before. Staff member K stated if they had gotten the re-weight that confirmed loss they would have discussed supplements. Staff member K stated the report that generated weight loss for nutrition at risk review did not include resident #64 because without a current weight it did not set up a trigger. Staff member K was hopeful with the new whiteboard system the facility had implemented, the re-weights would be tracked better.A request was made for the nutrition at risk meeting notes from May 2025 - current for resident #64. No information for this resident was provided.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure resident meals were served timely for 5 (#s 4, 18, 20, 32, and 72) of 28 sampled and supplemental residents. This deficient practice led to frustration and distress over missing and/or being late to functions. Findings include:Review of the posted facility mealtimes showed: breakfast 7:30 a.m., lunch 11:30 a.m., and dinner 5:00 p.m.During an observation and interview on 8/11/25 at 2:15 p.m., resident #4 stated, Meals are always late, as you can see we just got lunch. A lunch tray was observed on the resident's table.During a resident council meeting surveyors were invited to on 8/12/25 at 3:03 p.m., the following interviews showed: Resident #72 stated, I have to rush to eat to make it to church on Sunday. I leave the room at 9:35 a.m. and need the tray before then for breakfast. Resident #18 stated he had gotten his evening medications before dinner the other night, the meal had been so late. Resident #32 stated lunch had been on time today and it was nice because she usually had to eat in a rush or miss activities when meals were late.Resident #20 stated frustration that meals were on time, because state is here. Resident #20 stated dinner had not been happening until 7:00 p.m., for the past two months. Resident #20 stated they were always hearing the facility was short staffed. She stated filing grievances would not matter because the staffing problem was always there.During the resident council meeting on 8/12/25 at 3:03 p.m., staff member L stated the meal timing was a staffing concern.During the resident council meeting on 8/12/25 at 3:03 p.m., staff member C stated there was no excuse for the late meals. There had been ongoing hiring attempts, and they had not worked out. Staff member C encouraged residents to come to the dining room as meal delivery was faster there than it was to the rooms. During an observation on 8/13/25 at 7:55 a.m., breakfast trays were being served in the dining room with the assistance of all staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff followed proper infection control practices related to hand hygiene and proper use of PPE during suprapubic catheter care for 1 (#35) of 28 sampled residents. Findings include:During an observation and interview on 8/12/25 at 7:47 a.m., staff member J entered resident #35's room without performing hand hygiene and then went back out of the room, after having touched items in the room, to perform hand hygiene. Staff member J performed suprapubic catheter care for resident #35 without wearing a gown. During an interview on 8/12/25 at 8:07 a.m., staff member O said she did not know why there was an EBP sign was on resident #35's door. Staff member O looked in resident # 35's care plan and stated, oh it's for his suprapubic catheter. During an interview on 8/12/25 at 8:10 a.m., staff member J stated she usually performed hand hygiene before entering a resident's room. Staff member J stated, the sign (EBP sign on resident #35's door) means that you put a gown on before doing cath care or any cares, I should have put one on. Review of a facility document, titled, Enhanced Barrier Precautions, date implemented 4/11/25, reflected the following: . Enhance barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities . 4. High-contact resident care activities include: . g. Device care or use: .urinary catheters . [sic]