STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275123	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Rehabilitation and Nursing LLC	1415 Yellowstone River Rd Billings, MT 59105

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41652 Based on interview and record review, a staff member failed to provide necessary care and services for a dependent resident, for 1 (#19) of 19 sampled residents. The deficient practice caused the resident to initially be upset and tearful. Findings include: A review of a Facility-Reported Incident, submitted to the State Survey Agency, dated 3/22/24, showed resident #19 reported a staff member refused to assist him with getting out of bed to a chair. The resident also asked the staff member to get his call light. The staff member refused. Resident #19 stated the staff member stretched his urinary catheter tubing, causing discomfort. During an interview on 4/25/24 at 11:10 a.m., staff B stated he investigated the allegation made by resident #19 and determined the staff member did not assist resident #19. Staff member B stated the staff member voluntarily resigned and did not return to work. A review of resident #19's Admission MDS, with an ARD of 3/13/24, showed the resident needed assistance with his Activities of Daily Living (ADL), such as partial to moderate, or substantial to maximum, assistance in almost all areas of ADL care. The resident was also scored with a BIMS (Brief Interview for Mental Status) score of 15, cognitively intact. The resident passed away before the survey, therefore an interview was not feasible.

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41652 Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion or mobility received the restorative services necessary to maintain their highest level of functioning for 4 (#s 1, 3, 8, and 13) of 4 residents sampled for restorative services and mobility. Findings include: A request was made on 4/23/24 for a list of all residents who were supposed to be receiving restorative services. A list of 16 residents who received restorative services was provided on 7/23/24. During an interview on 4/25/24 at 10:38 a.m., when asked how she ensured residents received restorative services as needed, staff member D stated she could not tell which residents received these services or when these services were provided. During an interview on 4/25/24 at 11:10 a.m., staff member H stated she was not sure how restorative services were provided when the RA (Restorative Aide) was pulled to work the floor due to staffing shortages. Staff member H stated she thought there were tasks in the EHR associated with restorative services so CNAs could provide the restorative care when the RA was not available. During an interview on 4/25/24 at 11:15 a.m., staff member E stated she was not aware of any tasks in the EHR which allowed the CNAs to provide restorative services, for when the RA was pulled to work the floor and provide resident care, and was not able to provide restorative services. During an interview on 4/25/24 at 11:32 a.m., staff member F stated she provided restorative services when she was not pulled to the floor to work due to short staffing. Staff member F stated she had been doing paper charting for the past several months, and there was nothing in the EHR showing which residents were supposed to be receiving restorative services, and there were no tasks in the EHR to show which residents were supposed to receive restorative services. During an interview on 4/25/24 at 11:35 a.m., staff member C, who was responsible for providing nursing oversight, stated restorative services were kind of in limbo and were done when the RA was available. Staff member C stated there was currently no backup plan for when the RA was not able to perform the restorative services. Staff member C stated she thought there was a task in the EHR which allowed any CNA to provide the necessary restorative services. 1. During an interview on 4/25/24 at 10:38 a.m., staff member D stated resident #1 required staff assistance with mobility when she was in pain. Review of resident #1's Restorative Care Flow Record, dated February of 2024, showed the resident was to receive ambulation and range of motion services three to five times per week. The goal showed to maintain strength, ROM, and ambulation at the resident's highest level of functioning. The form failed to show any restorative services were provided during the month. Review of resident #1's Restorative Care Flow Record, dated March of 2024, showed the resident received restorative services twice during the month. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #1's Restorative Care Flow Record, dated April of 2024, showed the resident received restorative services three times during the month. 2. During an interview on 4/25/24 at 10:38 a.m., staff member D stated resident #3 was a fall risk and was impulsive. Staff member D stated the resident required staff assistance with all activities of daily living. Review of resident #3's Restorative Care Flow Record, dated February of 2024, showed the resident was to receive restorative services three to five times per week. The goal showed to keep strength at optimal level as needed. The form showed the resident was a fall risk, had poor trunk support, poor safety awareness, and needed knee braces when walking. The form failed to show the resident received any restorative services during February. Review of resident #3's Restorative Care Flow Record, dated March of 2024, showed the resident received ambulation assistance, range of motion, and transfer assistance once during the month. The form showed the resident refused restorative services on one day during the month. Review of resident #3's Restorative Care Flow Record, dated April of 2024, showed the resident received restorative services three times during April. 3. During an observation and interview on 4/2424 at 9:30 a.m., resident #8 was lying in his bed with his head elevated approximately 45 degrees. The resident's left leg was supported with a pillow. The resident stated he required assistance with transferring to and from his electric wheelchair. Review of resident #8's Restorative Care Flow Record, dated February of 2024, showed the resident was to receive restorative services three to five times per week, as needed, to maintain range of motion. The form showed the resident had limited range of motion to his right shoulder, poor trunk support, and poor safety awareness when using his electric wheelchair. The form showed the resident received restorative services nine times during the month. Review of resident #8's Restorative Care Flow Record, dated March of 2024 showed the resident received range of motion services twice during the month. Review of resident #8's Restorative Care Flow Record, dated April of 2024, showed the resident received services twice in April. 4. During an observation on 4/24/24 at 9:53 a.m., resident #13 was lying in his bed with the head of the bed elevated approximately 45 degrees. The resident was non-verbal and did not respond to any of the questions asked. The resident had a hand mitt on his left hand and contractures to his right arm and both legs. Review of resident #13's Restorative Care Flow Record, dated February of 2024, showed the resident had right arm contractures and stiffness to his left lower extremity. The resident was to receive restorative services three to five time per week, as needed, to maintain his current level of range of motion. The form showed the resident received services nine times during February. Review of resident #13's Restorative Care Flow Record, dated March of 2024 showed the resident received range of motion services twice during the month. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #13's Restorative Care Flow Record, dated April of 2024, showed the resident received restorative services three times in April. Review of the facility's policy titled, Restorative Nursing Services, date 12/19/16, showed, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. The policy also showed these services can be performed by designated restorative aides or licensed nurses.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41652 Based on observation, interview, and record review the facility failed to ensure there was sufficient staffing available to allow for the consistent provision of restorative nursing services for 4 (#s 1, 3, 8, and 13) of 16 sampled residents receiving restorative services. This deficient practice had the potential to affect any resident identified as needing restorative nursing services. Findings include: During an interview on 4/25/24 at 10:38 a.m., staff member D stated the facility had a Restorative Aide who was often pulled from the provision of restorative services to work the floor because of short staffing. During an interview on 4/25/24 at 11:10 a.m., staff member H stated it has been challenging to ensure restorative services are consistently provided. Staff member H stated this was because the Restorative Aide frequently got pulled to work and provide resident care rather than providing restorative services. During an interview on 4/25/24 at 11:15 a.m., staff member E stated when the Restorative Aide is pulled to work the floor, there is no one else to provide restorative services. During an interview on 11/25/24 at 11:32 a.m., staff member C stated when the Restorative Aide was pulled to work the floor, there was no backup plan for the provision of these necessary services. During an interview on 4/25/24 at 11:30 a.m., staff member F stated there used to be a task in the EHR which identified which residents were supposed to be receiving restorative services. Staff member F stated the facility switched to paper charting of restorative services several months ago, and there was no way in the EHR to identify residents who should have been receiving restorative services. Staff member F stated the Restorative Aide was frequently pulled to work the floor rather than doing restorative services. Review of the Restorative Care Flow Record for resident #s 1, 3, 8, and 13, dated February, March, and April of 2024, showed the residents were to receive services three to five times per week. The documentation showed the following: - February of 2024, resident #s 1 and 3 did not receive any restorative services during the entire month. - March of 2024, resident #s 1, 3, 8, and 13 received restorative services twice during the month. - April of 2024, resident #s 1, 3, 8, and 13 received restorative services three time during the month. Refer to F688 Increase/prevent Decrease in Rom/mobility for additional details.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 41652 Based on interview and record review, the facility failed to post the required staffing each day as required, and failed to ensure any changes in staffing or census were included on the required staff posting. This deficient practice had the potential to affect any resident wishing to view the information. Findings include: Review of the facility's daily staff posting information, dated 1/22/24 through 4/23/24, showed the following dates were missing: 1/22/24, 1/23/24, 1/30/24-2/1/24, 2/12/24-3/8/24, 3/14/24, 3/16/24, 3/24/24, 3/30/24, 4/4/24, 4/6/24, 4/11/24, 4/13/24-4/16/24, 4/18/24-4/19/24, and 4/23/24. The missing daily posting accounted for 45 of the 90 days requested. Of the 45 daily postings received, none of them contained the name of the facility and 11 were missing the number of hours actually worked. Review of the facility's admission report, dated from 1/23/24 through 4/23/24, showed the facility had a total of 74 admissions during the time period. Of the 45 days of posting present, 26 of the days showed at least one admission. Of the 26 days which showed at least one admission, only three days (3/12/24, 3/27/24, and 4/2/24) showed the appropriate increase in the census to account for the admissions. During an interview on 4/25/24 at 11:32 a.m., staff member C stated it was the responsibility of the night nurse to fill out the daily staff posting. When asked about the dates missing, and the census changes due to admission, staff member C stated, We have not been doing it. Staff member C stated she realized the posting was not being done consistently, and she was going to assign staff member H to do it.