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	08/01/2024

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on interviews and record review, the facility failed to refund a resident representative within 30 days of the resident's date of discharge for 1 (#1) of 3 reviewed for timely refunds at discharge. Findings include: During an interview on 7/30/24 at 3:30 p.m., NF2 stated the facility had not sent a refund check to her until 6/19/24. Review of resident #1's Discharge Summary, dated 5/7/24, reflected resident #1 was discharged on [DATE]. Review of a facility provided refund check, dated 6/10/24, reflected NF2 cashed the check on 6/21/24. Review of the facility's Standard Admissions Agreement, revised 3/1/19, reflected: -Refunds - .Refunds will be made within thirty (30) days of the Resident's death, transfer, or discharge.

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: 275123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48261

Based on interviews and record review, the facility failed to act promptly to resolve grievances brought forth by residents; provide access to allow residents to file grievances anonymously; take immediate action to protect and prevent further potential violations of any resident rights or potential abuse; and ensure a thorough investigation into the grievances were completed and documented for 6 (#s 1, 6, 9, 10, 15, and 16) of 17 sampled residents. Findings include:

1. During an interview on 7/30/24 at 3:30 p.m., NF2 reported resident #1 was not treated with dignity and respect during her stay at the facility beginning 5/2/24. NF2 stated resident #1's call lights were not answered on multiple occasions during the weekend, she was left in her hospital gown for five days, there was no hot water for a bath, and the facility did not give her a refund within the 30-day requirement. NF2 reported when she arrived on 5/6/24, resident #1 was crying and depressed. NF2 stated she and NF3 requested immediate discharge from the facility, due to the poor care provided. NF2 stated she reported her concerns to the nurse on duty and filed a grievance with the facility. NF2 stated she did not receive a response from the facility regarding her grievance. NF2 stated she contacted the ombudsman to get a response from the facility.

Review of the facility's call light report for resident #1's room [ROOM NUMBER], dated 5/2/24-5/7/24, reflected:

- 5/4/24: call light was on for 32 minutes at 10:42 a.m.

- 5/4/24: call light was on for 1 hour, and 33 minutes at 6:17 p.m.

- 5/5/24: call light was on for 38 minutes at 7:10 p.m.

During an interview on 7/21/24 at 7:10 a.m., staff member A stated he was aware of NF2's concerns. Staff member A stated he was new as an administrator, and only recently learned he should be reporting neglect. He thought he was only reporting abuse and misappropriation of funds. Staff member A stated there was no documentation of an investigation, staff interviews, or resident interviews for this complaint, and the staff member responsible was no longer employed with the facility. Staff member A reported he did not proceed with an alleged neglect allegation for further investigation or follow up for #1.

2. During an interview on 7/30/24 at 4:18 p.m., resident #16 stated the night crew did not answer call lights timely and did not change her brief during the night. Resident #16 stated she reported her grievances repeatedly to staff member A, staff member G, and staff member I. Resident #16 stated staff member A told her to stop complaining, that she is a complainer, and asked her if she wanted to move out, since she complained so much.

During an interview on 7/30/24 at 4:25 p.m., staff member I stated she reported resident #16's concerns to the management regularly, at the stand-up meetings. Staff member I stated resident #16 was outspoken about her concerns of care at night.

(continued on next page)

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

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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	3. During an interview on 7/30/24 at 4:40 p.m., resident #10 stated he went to the ombudsman with concerns, because grievances were not being answered or addressed by management. Resident #10 stated he filed a grievance about a CNA with long fingernails who was hurting him every time she used the gait belt to transfer him. Resident #10 stated the CNA's nails would dig into his skin and scratch him. Resident #10 stated he complained, no one ever addressed it or talked to him about it. Resident #10 stated the name of the staff member with the long nails was staff member M. 4. During an interview on 7/31/24 at 7:10 a.m., staff member A stated he did know about the complaint of neglect (in grievance) for resident #15 and had a scheduled a meeting with NF4 for 8/1/24. Staff member A stated he had not filed a report of neglect with the State Survey Agency because he was waiting to meet with NF4. Staff member A stated staff member F had continued to work with residents, (therefore the residents were not protected from staff member F) after the complaint was made on 7/27/24. Staff member F was removed from care with residents on 7/31/24. No investigation or interviews had been conducted as of 7/31/24. During an interview on 7/31/24 at 9:17 a.m., staff member C stated she reported resident #15's grievance to staff member A immediately. Staff member C stated the incident with the CNA had occurred on 7/27/24, but she was not working. Staff member C stated she was told about the grievance, filed by #15, in morning report from the night shift nurse. During an interview on 7/31/24 at 9:47 a.m., resident #15 stated staff member F refused to change his brief. Resident #15 stated NF4 came in during the evening and was very upset he had not been changed. Resident #15 stated he needed frequent brief changes due to medications he had been given for constipation. Resident #15 stated staff member F told him, I'm not changing your diaper again until shift change, when he asked to be changed for the second time after breakfast. Resident #15 stated, It's an awful feeling to go in a diaper and sit in it all day. It happened at breakfast, and I was not changed until [NF4] came in the evening. Resident #15 stated he was also left in his wheelchair for six hours after he got up for the morning until the afternoon. Resident #15 stated he was worried about getting pressure sores, and his back was hurting because he had been in the wheelchair too long. NF4 complained to the staff about care provided by staff member F. (continued on next page)

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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	During an interview on 7/31/24 at 11:12 a.m., NF4 stated she was taking resident #15 down to lunch and stopped at the nurse's station to request resident #15 be given his lunch medications. NF4 stated his medications must be given with lunch due to medical condition and metabolization. The nurse was not available, and they went on to the dining room. After lunch, NF4 stated she again stopped at the nurse's station and requested resident #15's medications. NF4 stated staff member F was on her cell phone and yelled, We are right in the middle of a crisis, we don't have time for that. NF4 stated she continued to push resident #15 to his room, and he was complaining of back pain. NF4 stated resident #15 informed her he had been in his chair since he woke up, and staff member F refused to change his brief since he got up. NF4 pressed the call button, and staff member F came to the room. NF4 stated he needed to be put in bed, and have his brief changed. NF4 stated staff member F told her, I'm not changing him again, I'm not changing him until he is empty. NF4 stated staff member F was complaining about needing a two person lift to get resident #15 back in bed, and left the room to find a second person. NF4 stated she left to go home, under the impression staff member F would take care of resident #15's brief change and allow him to lay down. NF4 stated she returned to facility at 7:00 p.m., to find resident #15's brief had not been changed, no one had come in after she left to provide toileting. NF4 stated she pressed the call light, and after waiting until 8:00 p.m., she changed him herself. NF4 stated resident #15 had feces dried all the way up his back and around his groin, and his brief was overflowing with feces. NF4 stated it took her an hour to clean resident #15 up and no one answered the call light until she was nearly done cleaning him up. NF4 stated a new CNA entered and when she told the new CNA what happened, the CNA went to get a nurse. The night nurse came into the room, and NF4 told the nurse that staff member F was no longer allowed in resident #15's room, and she wanted to talk to the administrator immediately. NF4 stated resident #15 had a diaper rash and is now worried he will offend someone if he must have a bowel movement. NF4 stated resident #15 was holding bowel movements in as long as possible to try and avoid upsetting the CNAs. NF4 stated this response was . not helping his constipation issues and [resident #15] shouldn't have to worry about upsetting CNAs. NF4 stated resident #15 had a traumatic brain injury and a sudden need for total assistance for basic needs so he should not be dealing with people who do not care. 5. During an interview on 7/31/24 at 9:59 a.m., resident #6 stated he no longer filed grievances because management did not listen and were full of excuses for not getting CNA help. Resident #6 stated he complained about long call light times and not getting his brief changed. During an interview on 7/31/24 at 7:10 a.m., staff member A stated he had not received a formal grievance form from resident #10 regarding cares. Staff member A stated he did not have a meeting with resident #16, nor tell her to stop complaining because she complains too much. During an interview on 7/31/24 at 9:16 a.m., staff member H stated she was not aware staff can fill out the grievance form, if a resident reports a grievance verbally. Staff member H stated she thought the form had to be filled out by the resident. During an interview on 7/31/24 at 9:40 a.m., staff member J stated she reported grievances from residents last month to staff member A about call lights not being answered at night. Staff member J stated staff member A said he would check into it. Staff member J stated she never received any response to the grievances, and still received the same complaint regularly from residents. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/31/24 at 2:08 p.m., staff member E stated, Staff lights are a real issue here. I've observed lights left on and I come back later (30-40 minutes) to see if they are ready, and the light will still be on, and no one has come. Sometimes, they come in and turn lights off and say they will be back but never come back. Staff member E stated she received many grievances about staff member F manhandling residents and being rough during cares. Staff member E stated she reported the grievances to the head nurse on duty and nothing ever seemed to change, so she quit reporting the concerns. Staff member E stated the grievances were happening so often she felt the management was ignoring the problems with staff member F. During an interview on 8/1/24 at 9:58 a.m., staff member G stated she could not explain the missing grievances in the logbook. Staff member G stated she would, .guess the forms were not dated or were lost in the mix. Staff member G stated resident council grievances were given to each department to address, but she had not been putting the grievances on grievance forms or ensuring an investigation was conducted into the resident care concerns. During an interview on 8/1/24 at 10:24 a.m., staff member A stated the facility did not have a drop off location for grievances, other than sliding them under the social workers door. Staff member A stated the facility did not have a way for residents to file a grievance anonymously. 6. During an interview on 7/31/24 at 1:53 p.m., resident #9 stated it was sometimes a two hour wait for her call light to be answered. She stated staff member F had told her she had to wait [to go to the bathroom] and she was unsure how she was supposed to do that. Resident #9 stated staff member F could be rough and rushed through cares causing pain in her affected hip. Resident #9 stated she had asked for staff member F to not work with her. Resident #9 stated the way staff member F treated her made her feel, humiliated, angry, and tired of the way people treat me. There was no facility investigation into the resident's request/complaint. There was no information to show resident #9 was protected after her concerns were filed in the grievance. Review of the facility provided Employee File for Staff member F, reflected no re-education, disaplinary actions, or actions taken by the facility as a result of grievances or neglect accusations related to lack of care of potential abuse or neglect. Staff member A stated there were no corrective actions taken. Review of the facility's Grievance logs, dated February 2024 - July 2024, did not reflect any grievances for resident #9. Review of the facility's Resident Council Minutes, dated 2/13/24-7/16/24, reflected the following grievances: -2/16/24: Mealtimes late, missing laundry items, resident fall and laid on floor for 10 hours before found, staff not checking oxygen tanks, call lights 30-40 minutes, left on commode 30-40 minutes, call lights moved out of reach, call lights turned off and state they will return but do not return, and snack cart time questions. -3/13/24: Mealtimes late, cold food, call light times on weekends and nights, nurses are rude, nurses do not treat residents with dignity and respect, nurses call residents fat, ignoring residents when they need to go to the bathroom, oxygen tanks not being checked, statements like not my patient, medication outages, and snack cart not coming around to rooms. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/13/24: [Staff member F] is rude, yells, has an attitude, if he wants it, he can go to his room, night shift has bad attitudes, tired, too busy talking to each other, weekend meal late, and never checked on. -5/21/24: Need follow-up after grievances, rooms not cleaned thoroughly, cold food, nurses say need to find someone else, not my job, long call light times, in the bathroom over an hour, need to be checked on, only one CNA in dining, and no one taking residents back to rooms after meals. -6/18/24: Laundry items missing, missing condiments on meal trays, call lights one to two hours, staff saying, find someone else, it's not my job, only one CNA in dining, need to be checked on more frequently, and more respect. -7/16/24: Laundry missing, missing items on meal trays, not getting items on preference list, running out of foods, repeated meals, getting fluids at night, not being cleaned, poor call light times, shift change taking too long, not my patient and I'll be right there. Review of the facility's Grievance logs, dated February 2024-July 2024, did not reflect the above care concerns reported by resident #s 1, 6, 10, 15, and 16. The grievance logs did not reflect the care concerns documented in the resident council minutes or show the grievances investigated. Review of a facility policy, Filing Grievances/Complaints Policy, revised 12/2021, reflected: - 1. Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, theft of missing property, etc., without fear of threat or reprisal in any form. - 3. Grievances and/or complaints may be submitted orally or in writing. Residents or the resident representative also has the right to file a grievance anonymously. - 8. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The Administrator, or his or her designee, will make such reports orally within 5 working days of the filing of the grievance or complaint with the facility. A written summary of the investigation will also be provided to the resident if requested, and a copy will be filed in the grievance log. - 10. The facility shall maintain evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Review of a facility policy, Abuse Policy, revised 6/11/24, reflected: - . When an employee of the facility abuses or is suspected of abuse of a resident, the employee will be placed on immediate suspension and directly escorted by a staff member out of the facility and not permitted to return while the investigation is completed .

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48261 Based on interviews and record review, the facility failed to keep residents free from neglect for 2 (#s 1 and 15) of 17 sampled residents. This deficient practice of neglect contributed to skin breakdown and psychosocial harm and pain for 1 (#15) and psychosocial harm to 1 (#1) of the 17 sampled. Findings include: 1. During an interview on 7/31/24 at 9:47 a.m., resident #15 stated staff member F refused to change his brief. Resident #15 stated NF4 came in during the evening and was very upset he had not been changed. Resident #15 stated he needed frequent brief changes due to medications he had been given for constipation. Resident #15 stated staff member F told him, I'm not changing your diaper again until shift change, when he asked to be changed for the second time after breakfast. Resident #15 stated, It's an awful feeling to go in a diaper and sit in it all day. It happened at breakfast, and I was not changed until [NF4] came in the evening. Resident #15 stated he was also left in his wheelchair, in the dining room, for six hours after he got up for the morning until the afternoon. Resident #15 stated he was worried about getting pressure sores, and his back was hurting because he had been in the chair too long. NF4 complained to the staff about care provided by staff member F. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/31/24 at 11:12 a.m., NF4 stated she was taking resident #15 down to lunch and stopped at the nurse's station to request resident #15 be given his lunch medications. NF4 stated his medications must be given with lunch due to a medical condition and metabolization. She was told the nurse was not available now, and they went on to the dining room. After lunch, NF4 stated she again stopped at the nurse's station and requested resident #15's medications. NF4 stated staff member F was on her cell phone and yelled, We are right in the middle of a crisis, we don't have time for that. NF4 stated she continued to push resident #15 to his room and he was complaining of back pain. NF4 stated resident #15 informed her he had been in his chair since he woke up, and staff member F refused to change his brief since he got up. NF4 pressed the call button, and staff member F came to the room. NF4 stated he needed to be put in bed and have his brief changed. NF4 stated staff member F told her, I'm not changing him again, I'm not changing him until he is empty. NF4 stated staff member F was complaining about needing a two person lift to get resident #15 back in bed and left the room to find a second person. NF4 stated she left to go home, under the impression staff member F would take care of resident #15's brief change, and allow him to lay down. NF4 stated she returned to the facility at 7:00 p.m., to find resident #15's brief had not been changed, and no one had come in after she left to provide toileting or assistance. NF4 stated she pressed the call light, and after waiting until 8:00 p.m., she changed him herself. NF4 stated resident #15 had feces dried all the way up his back and around his groin, and his brief was overflowing with feces. NF4 stated it took her an hour to clean resident #15 up, and no one answered the call light until she was nearly done cleaning him up. NF4 stated a new CNA entered and when she told the new CNA what happened, the CNA went to get a nurse. The night nurse came into the room, and NF4 told the nurse that staff member F was no longer allowed in resident #15's room, and she wanted to talk to the administrator immediately. NF4 stated resident #15 had a diaper rash, and is now worried he will offend someone if he must have a bowel movement. NF4 stated resident #15 was holding bowel movements in as long as possible to try and avoid upsetting the CNAs. NF4 stated this behavior was .not helping his constipation issues and resident #15 shouldn't have to worry about upsetting CNAs. NF4 stated resident #15 had a traumatic brain injury and a sudden need for total assistance for basic needs so he should not be dealing with people who do not care. During an interview on 7/31/24 at 9:17 a.m., staff member C stated she reported resident #15's grievance to staff member A immediately in a text message on 7/28/24 at 6:40 a.m. Staff member C stated the incident with the CNA had occurred on 7/27/24, but she was not working. Staff member C stated she was told about the grievance in morning report from the night shift nurse. During an interview on 7/31/24 at 2:11 p.m., staff member F stated she changed resident #15 when she came on shift in the morning. Staff member F stated resident #15 was a Hoyer and required two people to transfer him in the Hoyer lift. Staff member F stated she told resident #15 she could not get him on the toilet because it was too messy but would give him a bed pan to use on the bed. Staff member F stated, It was about then that the ambulance came for another resident, and I had to step out to go do vitals on that resident. Then it was four o'clock, so I started getting people up for dinner, showers, and weights. Then my co-worker asked to change jobs because she didn't want to go to the dining room, so she took over my hall, and I went to the dining room. When I came back, it was time to give report and leave. Staff member F stated, I put him down (#15), I didn't go back and check on him because things were just crazy that day. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/31/24 at 7:10 a.m., staff member A stated he did know about the complaint of neglect for resident #15, and had a scheduled a meeting with NF4 for Thursday. Staff member A stated he had not filed a report with the State Survey Agency because he was waiting to meet with NF4. Staff member A stated staff member F had continued to work with residents after the complaint was made on 7/27/24. During an interview on 8/1/24 at 8:50 a.m., staff member O stated, [Staff member A] did not follow proper protocol and was doing it backwards, trying to meet with family and investigate before reporting. Training on more in depth record keeping and keeping folder and interviews for each incident is needed. 2. During an interview on 7/30/24 at 3:30 p.m., NF2 reported resident #1 was not treated with dignity and respect during her stay at the facility beginning 5/2/24. NF2 stated resident #1's call lights were not answered on multiple occasions during the weekend and she was left in her hospital gown for five days. NF2 reported when she arrived on 5/6/24, resident #1 was crying and depressed. NF2 stated she and NF3 requested immediate discharge from the facility, due to the poor care provided. NF2 stated she reported her concerns to the nurse on duty and filed a grievance with the facility. NF2 stated she never received a response from the facility regarding her grievance. NF2 stated she contacted the ombudsman to get a response from the facility. Review of the facility's call light report for resident #1's room [ROOM NUMBER], dated 5/2/24-5/7/24, reflected: - 5/4/24: call light was on for 32 minutes at 10:42 a.m. - 5/4/24: call light was on for 1 hour, and 33 minutes at 6:17 p.m. - 5/5/24: call light was on for 38 minutes at 7:10 p.m. During an interview on 7/21/24 at 7:10 a.m., staff member A stated he was aware of NF2's concerns. Staff member A stated he did not report the neglect to the State Survey Agency. Staff member A stated he was new as an administrator, and only recently learned he should be reporting neglect. He thought he was only reporting abuse and misappropriation of funds. Review of a facility policy, Abuse Policy, revised 6/11/24, reflected: - . Neglect: The failure to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish or emotional distress. - . Abuse Identification and Reporting (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property are reported immediately, but no later than 2 hours, after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides jurisdiction in long term care facilities and office of long-term care ombudsman) in accordance with State law through established procedures. - All employees of this facility must immediately report any suspected, observed or reported incidents of resident abuse, neglect, misappropriation of resident property, whether by staff members, family members or any other persons to the Administrator or Administrator's designee. The Administrator serves as the abuse coordinator of the facility. - The Administrator or designee shall interview any staff members, residents, family members or any others who may have knowledge of the incident and document a summary of interviews completed. - The Administrator or designee shall report the results of all investigations to the State Survey Agency within 5 working days of the incident . - When an employee of the facility abuses or is suspected of abuse of a resident, the employee will be placed on immediate suspension and directly escorted by a staff member out of the facility and not permitted to return while the investigation is completed .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER River Ridge Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 Yellowstone River Rd Billings, MT 59105	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46400 Based on interview and record review, the facility failed to protect residents who voiced concerns related to alleged abuse or neglect of care; failed to report neglect allegations to the State Survey Agency within the required 24 hours for 3 (#s 1, 14, 15); and failed to report the investigative findings of their reported incidents to the State Survey Agency within five days for 3 (#s 5, 8, 16) of 17 sampled residents. Findings include: 1. Review of a facility reported incident, dated 7/2/24, showed a resident to resident altercation occurred for resident #5. Investigative findings were not reported until 7/8/24, one day out of the reporting window. 48261 2. During an interview on 7/31/24 at 11:12 a.m., NF4 stated resident #15 had not had his brief changed for approximately 13 hours, and was left in a feces filled brief all day. NF4 stated she complained to the nurse on duty when she returned and found resident #15 had not had his brief changed. NF4 stated his brief was overflowing with feces. During an interview on 7/31/24 at 9:17 a.m., staff member C stated she reported resident #15's grievance to staff member A immediately in a text message on 7/28/24 at 6:40 a.m. Staff member C stated the incident with the CNA had occurred on 7/27/24, but she was not working. Staff member C stated she was told about the grievance in morning report from the night shift nurse. During an interview on 7/31/24 at 7:10 a.m., staff member A stated he did know about the complaint of neglect for resident #15, and had a scheduled a meeting with NF4 for Thursday. Staff member A stated he had not filed a report with the State Survey Agency because he was waiting to meet with NF4. During an interview on 7/31/24 at 8:43 a.m., NF1 stated she met with staff member A on 6/12/24, regarding the care concerns brought forward by NF4 for resident #15. NF1 stated staff member A reported to her staff education was completed. During an interview on 8/1/24 at 8:50 a.m., staff member O stated, [Staff member A] did not follow proper protocol and was doing it backwards, trying to meet with family and investigate before reporting. 3. Review of a facility reported incident, dated 3/7/24, reflected a resident-to-resident incident which occurred on 3/3/24 at 12:30 a.m. for resident #14. The initial report to the State Survey Agency was received on 3/7/24. The final findings were not reported until 3/13/24. 4. Review of a facility reported incident, dated 6/5/24, reflected an injury of unknown origin was found on 6/5/24 at 9:00 p.m. for resident #16. The initial report to the State Survey Agency was received on 6/5/24. The final findings were not reported until 6/13/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of a facility reported incident, dated 6/14/24, reflected a resident-to-resident incident occurred on 6/14/24 at 2:10 p.m. for resident #2. The initial report to the State Survey Agency was received on 6/14/24. The final findings were not reported until 6/20/24. 6. During an interview on 7/30/24 at 3:30 p.m., NF2 reported resident #1 was not treated with dignity and respect during her stay at the facility beginning 5/2/24. NF2 stated resident #1's call lights were not answered on multiple occasions during the weekend and she was left in her hospital gown for five days. NF2 reported when she arrived on 5/6/24, resident #1 was crying and depressed. NF2 stated she and NF3 requested immediate discharge from the facility, due to the poor care provided. NF2 stated she reported her concerns to the nurse on duty, and filed a grievance with the facility. During an interview on 7/21/24 at 7:10 a.m., staff member A stated he was aware of NF2 concerns. Staff member A stated he did not report the neglect to the State Survey Agency. Staff member A stated he was a new administrator, and only recently learned he should be reporting neglect. He thought he was only reporting abuse and misappropriation of funds. Review of a facility policy, Abuse Policy, revised 6/11/24, reflected: -Abuse Identification and Reporting - The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property are reported immediately, but no later than 2 hours, after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides jurisdiction in long term care facilities and office of long-term care ombudsman) in accordance with State law through established procedures. - All employees of this facility must immediately report any suspected, observed or reported incidents of resident abuse, neglect, misappropriation of resident property, whether by staff members, family members or any other persons to the Administrator or Administrator's designee. The Administrator serves as the abuse coordinator of the facility. - The Administrator or designee shall report the results of all investigations to the State Survey Agency within 5 working days of the incident . - When an employee of the facility abuses or is suspected of abuse of a resident, the employee will be placed on immediate suspension and directly escorted by a staff member out of the facility and not permitted to return while the investigation is completed .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400 Based on interviews and record review, the facility failed to ensure residents were appropriately assessed to be outside independently, and failed to ensure residents were inside the facility at night for 1(#13) of 17 sampled residents. This deficient practice had the potential to cause harm to a resident driving their wheelchair down a dark road. Findings include: Review of resident #13's nursing progress notes, dated 7/21/24, showed, Patient with new scooter and outside privileges. Routine monitoring while patient is outside. Nurse does not feel patient is safe to be outside, he was given privileges to go outside by another staff member . Review of resident #13's nursing progress notes, dated 7/27/24, showed the resident was outside driving his motorized scooter down the road. A motorist called the facility asking if they had lost a resident, and there was a car and motorcycle following the motorized scooter. During an interview on 8/1/24 at 10:25 a.m., staff member B stated resident #13 had left the facility at 9:40 p. m. and must have followed someone out the door. Staff member B stated they were working on a new assessment for determining leave privileges, but had not yet instituted it. During an interview on 8/1/24 at 11:00 a.m., staff member L stated any residents who were approved to leave the building independently had to let staff know, and sign out in the front desk book. Staff member L wasn't sure if resident #13 was safe to go outside independently, but stated she would not be comfortable with a resident leaving at nighttime. During an interview on 8/1/24 at 11:05 a.m., staff member J stated there was an app that staff used to keep updated on any incidents. She stated there was also an alerts page that passed on information such as new interventions or occurrences over the past 72 hours. Staff member J was unaware resident #13 had been outside without staff knowledge as it had fallen off the 72-hour report. Review of resident #13's care plan, initiation date 7/16/24, failed to show any identification of the resident's assessment to go outside independently or his elopement risk. Review of the facility policy, Leave of Absence Privilege Policy, no date, showed, .4. The resident will have a care plan developed regarding the independent leave of absence privilege determination. The care plan shall be updated any time a change is made pertaining to the resident's independent leave of absence privileges . Review of the facility investigation into the incident, submitted 8/1/24, showed the resident leave of absence assessment had not been completed prior to his elopement. The resident was safely escorted from the road, but became threatening with his power scooter when staff requested he return to the facility. Resident #13 left AMA the next day (7/28/24), and was readmitted to the facility on [DATE].