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Form Approved OMB
No. 0938-0391

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	11/07/2024

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 50245 Based on interview and record review, the facility failed to ensure the Infection Preventionist had the necessary certification for oversight of the infection control program. This failure would affect any resident who had an infection, was at risk of an infection, or for how the facility upheld and monitored infection prevention strategies. Findings include: During an observation on 11/6/24 at 3:41 p.m., staff member D stated she worked at the facility starting in February 2024. Staff member D stated she completed the infection preventionist certification in 2019, but due to a tornado in another state, she was were unable to find the certification. Review of the facility request sheet, dated 11/7/24 at 9:53 a.m., showed the facility documented, Infection Preventionist Certification. No certification or supporting information was provided to the survey team prior to the end of the survey.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 50245 Based on interview and record review, the facility failed to provide a pneumococcal and Covid-19 vaccine for 1 (#74) of 7 sampled residents for immunizations. Findings include: During an interview on 11/6/24 at 3:41 p.m., staff member D stated all immunizations were documented in the EHR, and there was no other documentation located outside of the EHR, concerning immunizations. Review of a facility provided document, titled Consent Form For Pneumococcal Vaccine, dated 9/24/24, showed resident #74 had consent given for the vaccine. Review of a facility provided document, titled Consent Form For SARS-COV-2 (COVID-19) Vaccine, dated 9/24/24, showed consent given for Covid-19 vaccine for resident #74. Review of resident #74's EHR showed no record of Covid-19 or pneumococcal vaccines given. The resident immunization record were requested on 11/7/24 at 9:53 a.m.