Printed: 06/26/2025
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	03/27/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48262 Based on observation, interview, and record review, the facility failed to implement a system to ensure an interdisciplinary team was involved in determining if a resident was safe to self-administer medication and failed to implement a system to ensure an as needed medication was secured in a resident's room for 1 (#6) of 9 sampled residents. This deficient practiced caused resident #6 a temporary burning sensation under her right arm. Findings include: During an observation and interview on 3/25/25 at 4:10 p.m., resident #6 was in her room sitting in a wheelchair. Resident #6 stated she had limited mobility in her extremities because of multiple health conditions and required assistance with daily care. Resident #6 was observed to have minimal movement in her hands and was unable to lift her arms. Resident #6 stated in late January 2025, staff member E spoke to her about a medication called Blu Emu cream for muscle soreness. Resident #6 stated a nurse left a sample of the Blu Emu cream in a 30cc plastic medication cup on her bedside table and told her to use it when she needed it. Resident #6 stated she did not recall the name of the nurse who left the cream on her bedside table. Resident #6 stated facility staff did not provide a locked container in her room to store the medication. Resident #6 stated she never needed to use the Blu Emu cream, and it sat on top of her bedside table. Resident #6 stated staff member K came into her room on the evening of 1/29/25 and administered her oral nighttime medication but left a white cream in a 30cc medication cup on her bedside table the medical provider ordered to be applied to her underarms due to skin irritation. Resident #6 stated she had stayed up late watching a movie and was sitting in her wheelchair and staff member K wanted staff member J to apply the cream to her underarms when she was ready for bed. Resident #6 stated staff member J helped her prepare for bed around 11:30 p.m. on 1/29/25. Resident #6 stated staff member J mixed up the two creams on her bedside table and applied the blue (Blu Emu) cream instead of the white cream to her underarm. Resident #6 stated she experienced a burning sensation to her underarm after staff member J applied the cream. Resident #6 stated staff member J washed her underarms with soap and warm water which provided resident #6 relief from the burning sensation. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/24/25 at 3:50 p.m., staff member E stated she did not recall completing a medication self-administration assessment on resident #6 for Blue Emu cream. Staff member E stated she did not know why a medication self-administration assessment would be completed for resident #6 because the resident would not be able to apply the cream. Staff member E reviewed resident #6's electronic medical record and was able to locate the medication self-administration assessment completed on 1/23/25. Staff member E stated she completed the assessment but documented on the assessment resident #6, Is able to direct staff to apply medications; resident knows how often and had agreed to supply the medication. Staff member E stated when she documented staff applying the medication, she was indicating licensed staff only. Staff member E denied dispensing Blu Emu cream to resident #6. Review of resident #6's physician order, dated 1/23/25, showed an order for Blue-Emu cream to be applied to the affected areas topically every 12 hours as needed. Resident #6 may have at bedside. Resident will supply this medication. Review of resident #6's Medication Self-Administration Safety Screen, dated 1/23/25, showed medication to be self-administered, Blu Emu cream, to be stored at bedside with resident #6. Resident #6 requires assistance to correctly read label and or identify medication and to open medication package or container. Staff member K documented under the interdisciplinary summary, Resident is able to direct staff to apply medications; she (resident #6) knows how often; she (resident #6) has agreed to supply this medication. Review of resident #6's electronic medical record failed to show the resident's medication self-administration assessment, dated 1/23/25, was reviewed by the facility's interdisciplinary team. Review of the facility's policy titled, Self-Administration of Medications, revised December 2012, showed the following: Policy Statement Residents in the facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. Policy Interpretation and Implementation - 1. If a resident expresses a desire to self-administer medications, the staff and practitioner will assess the resident's mental and physical abilities to determine whether a resident is capable of self-administering medications, including (but not limited to) the resident's; a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them; and d. Ability to recognize risks and major adverse consequences of his or her medication . (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 6. Self-administration medication must be stored in a safe secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of the residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them . [sic]

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48262 Based on interview and record review, the facility nursing staff failed to meet professional standards of practice by not providing safe administration of a scheduled topical medication for 1 (#6) of 9 sampled residents. This deficient practice caused resident #6 a temporary burning sensation under her right arm. Findings include: During an interview on 3/25/25 at 4:10 p.m., resident #6 stated on 1/29/25 staff member K brought a plastic 30cc medication cup into her room. Resident #6 stated the medication cup contained a white cream the medical provider had ordered for her due to skin irritation under her left and right underarms. Resident #6 stated staff member K administered her oral medication but left the cream on her bedside table for the certified nursing assistant to apply to the affected area when she went to bed for the evening. Resident #6 stated staff member J helped her prepare for bed around 11:30 p.m. on 1/29/25. Resident #6 requested staff member J apply the cream under her arms. Resident #6 stated after staff member J applied the cream to her right underarm she started to feel a burning sensation. Staff member J then applied a cold cloth to her underarm, which did not relieve the burning sensation. Resident #6 asked staff member J to go and get the nurse. Resident #6 stated she asked staff member J if he had applied the white cream, and he responded, No, it was blue. Staff member J then washed resident #6's underarms with soap and warm water which provided her relief from the burning sensation she had experienced. Resident #6 stated, Then I had the CNA apply the white cream to my underarms. Resident #6 stated the blue cream was in a clear 30cc medication cup and was left at her bedside by a nurse days prior to try out for muscle soreness, and to use it when she needed it. Resident #6 stated she could not recall what staff member gave her the blue cream, but said she was allowed to keep it at her bedside. Resident #6 stated she had not needed to use the blue cream, and it had remained on her bedside table. During an interview on 3/27/25 at 12:06 p.m., staff member K stated she received an order from the medical provider for Triamcinolone Acetonide external cream 0.1% topically to be applied under resident #6's right and left underarms on 1/29/25. Staff member K stated she recalled being in the resident's room around 8:00 p.m. on 1/29/25. Staff member K stated resident #6 was still awake sitting in her wheelchair. Staff member K stated she administered the resident's oral medication around 8:00 p.m. on 1/29/25, and placed Triamcinolone Acetonide cream in a clear 30cc medication cup, on the resident's bedside table. Staff member K stated she was planning to return to the resident's room to apply the cream when resident #6 was ready for bed. Staff member K stated she was new to her position and had worked in the past in different states which allowed certified nursing assistants to apply topical creams. Staff member K stated she could not say why she left the Triamcinolone Acetonide cream on the resident's bedside table. Staff member K denied dispensing a blue cream to resident #6. Review of resident #6's medication administration record showed Triamcinolone Acetonide external cream 0.1% was administered topically under resident #6's right and left underarms on 1/29/25 at 7:38 p.m. by staff member K. Staff member K failed to ensure safe administration of a scheduled topical medication by leaving the medication unsupervised on resident #6's bedside table.

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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. 51111 Based on interview and record review, the facility failed to ensure staff members followed appropriate protocols for the safe transfer of residents while using a Hoyer lift for 1 (#6) of 9 sampled residents. Findings include: Review of a facility grievance, dated 1/29/25, showed resident #6 reported staff member J used a Hoyer lift, without assistance from another staff member, to transfer her to bed from her wheelchair, when providing care at night. During an interview on 3/26/25 at 9:05 a.m., staff member B stated newly hired nursing staff received education on lifts. Staff member B stated the facility requires two staff when using lifts for resident transfers. Staff member B stated there was a nursing in-service meeting in September 2024, which included lift training. Staff member B stated staff member P provided education on appropriate lift protocols for resident transfers to staff member J. During an interview on 3/27/25 at 9:19 a.m., staff member J stated the facility was strict about having two staff transfer a resident with lifts. Staff member J stated the facility required two staff members when using Hoyer lifts and EZ stand lifts. Staff member J stated he transferred resident #6 during the night of 1/29/25, on his own, and stated it was because, I believe I couldn't find anyone available to assist. Review of a facility document titled, Inservice 9/19/24, showed, Lifts- all lifts in the facility require 2 person for transfers. If your resident requires a lift please ensure care is provided and sling under resident and w/c or bed is prepared for resident. once all care has been given and resident is ready for transfer then have 2nd staff member join you for safe transfer process . [sic] Review of a facility document titled, Staff Education, undated, showed staff member J was educated by staff member P on training for proper safety when using a Hoyer and sit to stand lift, and proper care procedures. Review of a facility document titled, Certified Nursing Assistant Competency Checklist, undated, showed staff member J completed training and was signed off on 1/7/25 for, Equipment: Use of sit-to-stand lift, and on 1/8/25 for, Equipment: Use of Hoyer lift.

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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. 48262 Based on interview and record review, the facility failed to provide pharmaceutical services to ensure safe administration of a scheduled topical medication for 1 (#6) of 9 sampled residents. This deficient practice caused resident #6 a temporary burning sensation under her right arm. Findings include: During an interview on 3/25/25 at 4:10 p.m., resident #6 stated on 1/29/25 at approximately 11:30 p.m., staff member J helped her prepare for bed. Resident #6 requested staff member J apply a cream under her arms due to irritation she had been experiencing the last two days. Resident #6 stated after staff member J applied the cream to her right underarm she started to feel a burning sensation. Staff member J then applied a cold cloth to her underarm, but she had no relief. Resident #6 said she asked staff member J to go and get the nurse and also asked him if he had applied the white cream, and he responded, No, it was blue. Resident #6 stated staff member J then washed her underarms with soap and warm water which provided relief from the burning sensation. Resident #6 stated staff member J then applied a white cream to her underarms which had been placed on her bedside table in a clear 30cc medication cup by the nurse earlier in the evening. Resident #6 stated the blue cream was placed in a clear 30cc medication cup and was left at her bedside by a nurse days prior to try out for muscle soreness, and to use it when she needed it. Resident #6 stated she had not needed to use the blue cream, and it had remained on her bedside table. During an interview on 3/27/25 at 9:14 a.m., staff member J stated on 1/29/25 at some time between 11:00 p.m. and 11:30 p.m., he assisted resident #6 to bed. Staff member J stated the nurse entered resident #6's room while he was assisting the resident and placed two 30cc medication cups on the resident's bedside table. One cup contained white cream and the other contained blue cream. The cups were unlabeled. Staff member J stated the nurse did not provide any instructions prior to leaving the room. Staff member J stated resident #6 requested he apply cream under her right underarm, and he applied the blue cream. Staff member J stated the resident started to complain of a burning sensation. Staff member J stated he then applied a cold cloth under the resident's right under arm which did not relieve the resident's burning sensation. Staff member J stated the resident requested to see the nurse and find out what was in the white cream. Staff member J stated to resident #6, I applied the blue cream. Staff member J stated he then washed the blue cream from resident #6's right underarm with soap and warm water. Staff member J stated resident #6's burning sensation stopped, and he then applied the white cream to her underarms, at her request. Staff member J stated he reported the incident to staff member K, and she had followed up with the resident. Staff member J stated resident #6 voiced no complaints of pain or discomfort for the remainder of his shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/25 at 12:06 p.m., staff member K stated she received an order from the medical provider for Triamcinolone Acetonide external cream 0.1% topically to be applied under resident #6's right and left underarms on 1/29/25. Staff member K stated she recalled being in the resident's room around 8:00 p.m. on 1/29/25. Staff member K stated resident #6 was still awake sitting in her wheelchair. Staff member K stated she administered the resident's oral medication around 8:00 p.m. on 1/29/25 and placed Triamcinolone Acetonide cream in a clear 30cc medication cup on the resident's bedside table. Staff member K stated she was going to return to the resident's room to apply the cream when resident #6 was ready for bed. Staff member K stated she was new to her position and had worked in the past in different states which allow for certified nursing assistants to apply topical cream. Staff member K stated she could not say why she left the Triamcinolone Acetonide cream on the resident's bedside table. Staff member K denied dispensing a blue cream to resident #6. Review of resident #6's medication administration record showed: Triamcinolone Acetonide external cream 0.1% was administered topically under resident #6's right and left underarm on 1/29/25 at 7:38 p.m. by staff member K. Review of resident #6's medical provider orders showed: - Order date 1/23/25 . Blue-Emu Super Strength External Cream (Liniments & Rubs) Apply to affected areas topically every 12 hours as needed. May have at bedside. Resident will supply this medication. - Order date 1/29/25 Triamcinolone Acetonide External Cream 0.1 % (Triamcinolone Acetonide (Topical)) Apply to bilateral axilla topically two times a day for rash for five days. Review of the facility document titled, Administering Medication, last revised December 2012, showed: Policy Statement Medication shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation - 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. - . 7. The individual administering the medication must verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . [sic]

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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. 51111 Based on observation, interview, and record review, the facility failed to ensure dietary staff followed safe and sanitary conditions by donning hair coverings and beard nets while preparing resident meals in the facility kitchen. This failure put all residents receiving meals at risk for sanitation issues related to the uncovered hair if it were to get into food. Findings include: During an observation on 3/24/25 at 4:38 p.m., staff member I was in the facility kitchen, not wearing a hair covering or beard net. Staff member I was working at the kitchen grill and preparing food on a serving area. During an observation on 3/25/25 at 7:50 a.m., staff member I was in the facility kitchen, not wearing a hair covering or beard net. Staff member I was dishing food from a pan, onto a plate, preparing breakfast for residents. During an interview on 3/25/25 at 2:15 p.m., staff member D stated dietary staff working in the kitchen are expected to wear hair coverings and a beard net if they have facial hair. Staff member D stated staff member I moved into the cooking role recently and did not always wear a beard net. Staff member D stated staff member I is aware he needed to wear a beard net, he had been told to wear a beard net working in his new role as a cook. Staff member D stated audits by observations were completed to show compliance with facility dining room, kitchen, and food test tray policies. Staff member D stated the dietitian conducted audits on Tuesdays, and on Thursdays she completed the audits. During an interview on 3/26/25 at 1:48 p.m., staff member I stated, It's 50/50 (the time) that I remember to wear a hair or beard net. I forget a lot. I get busy, and I'm new to doing the cook position. Staff member I stated he trimmed hair towards the back of his head the other day for his hair to be shorter. Staff member I stated he needed to do better to remember to wear hair and beard coverings when working in the kitchen. Review of a facility policy titled, Work Clothing and Attire, undated, showed: . Employees engaged in work that places them in a position where they meet the public or provide patient care are expected to present a neat, professional appearance. This means good grooming habits and the proper attire representative of their position .

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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. 51111 Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precaution practices were utilized by staff while performing high-contact resident care during a transfer, for 1 (#5) of 9 sampled residents. Findings include: During an observation on 3/25/25 at 3:32 p.m., staff member N and staff member L transferred resident #5 in his room from the bed to his wheelchair. Staff member N and staff member L had gloves on before they started to transfer resident #5 with the sit-to-stand lift. Staff member N and staff member L did not don gowns prior to the transfer. Staff member N and staff member L's uniforms had direct contact with resident #5's upper and lower body during his transfer with the sit-to-stand lift. During an interview on 3/25/25 at 3:44 p.m., resident #5 stated nursing staff wear gowns and gloves when they perform his catheter care, but not when he is transferred with the sit-to-stand lift. During an interview on 3/26/25 at 9:15 a.m., staff member B stated she was the infection preventionist for the facility, and she provided education to nursing staff on the use of enhanced barrier precautions. Staff member B stated all nursing staff are educated on what to use when a resident is on enhanced barrier precautions. Staff member B stated when two staff members are transferring a resident who is on enhanced barrier precautions, staff are required to don gowns and gloves. During an interview on 3/26/25 at 11:31 a.m., staff member N stated when she transferred resident #5 the day prior, with staff member L, It was busy. I usually wear a gown when transferring a resident and have contact, but I didn't during the transfer for [#5]. Review of a facility policy titled, Enhanced Barrier Precautions, revised 4/1/24, showed: . 1. In addition to Standard Precautions, implement Enhanced Barrier Precautions for an individual documented or suspected to be at increased risk of carrying a resistant organism . This includes anyone with . indwelling medical devices (e.g. urinary catheter .) 5. In addition the use of standard precautions, staff should wear gloves and a gown during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Examples of high-contact resident are activities include: . c. Transferring . [sic]