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	01/15/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure comprehensive investigations of facility reported incidents were completed for 2 (#s 67 and 99) and failed to ensure post-incident interventions were implemented to prevent additional similar incidents for 1 (#67) of 29 sampled residents. These deficient practices increased the risk of an adverse outcomes for the residents involved in the facility reported incidents. Findings include: 1. Review of a Facility-Reported Incident, submitted to the State Survey Agency on 9/27/25, showed resident #67 exited the building through an alarmed door, which a facility vendor had opened. Resident #67 remained outside of the facility until another family member reported the concern to a staff member. Staff were unaware that resident #67 was not in the building. During an interview on 1/13/26 at 11:03 a.m., staff member A stated their video surveillance showed resident #67 exited the facility through an alarmed entrance door, in his wheelchair, by a vendor who was at the facility. Therefore, the alarm was not triggered on the door. Staff member A stated he estimated resident #67 was outside unsupervised for approximately 15 minutes. During an interview on 1/13/26 at 1:22 p.m., resident #67 was unable to recall the incident, but stated, I would like to go outside. Review of resident #67's Quarterly MDS, with an ARD of 12/17/25, showed resident #67 had a BIMS of 11, which was moderate cognitive impairment. Review of the facility's investigation for the resident leaving the facility showed staff were educated on responding to door alarms and instructed to go outside when a door alarm sounded to ensure no resident had left the building. Review of resident #67's IDT event note, dated 10/3/25, showed, Risk Factors and Root Cause Identification: Impaired memory, Confused, Wanting to smoke . New interventions: Resident added to the elopement binder, Resident educated he cannot leave the facility without assistance, Encouraged to use the enclosed patio to enjoy outdoors when desired. [sic] The facility failed to accurately identify the root cause of the elopement to address it, specifically that the resident was being assisted through a door by a non-employee vendor, and the alarm was not triggered. The post-incident education focused on listening for and acting on door alarms, although no door alarm triggered for this incident. The facility failed to investigate or employ interventions post-incident that were specific to the resident's exiting the facility, which placed resident #67 at a continued risk of elopement. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of a Facility-Reported Incident, dated 6/5/25 at 8:40 a.m., showed staff member O found resident #99 lying in his bed in urine-soaked clothing and a soiled brief. This was discovered by staff members O and L after shift change was completed with NF3, who had been a staff member responsible for resident #99's care on the night shift. Staff member O reported the information about resident #99 to staff member J, who then reported the neglect of care to staff member B, and in turn to staff member A. During an interview on 1/15/26 at 8:36 a.m., staff member A stated he did not have any further documentation to provide for the facility reported incident involving resident #99 on 6/5/25. Staff member A stated he could not show resident #99's responsible party or provider were contacted regarding the incident. Staff member A stated, If it isn't documented, it didn't happen. Staff member A stated there were no risk management or event form templates with information about the incident involving resident #99. An initial request was made to the facility on 1/12/26 at 12:29 p.m. for documentation of any investigation notes, to include interviews and or findings for the facility reported incident with resident #99 on 6/5/25. The facility provided the following incident findings, with no date of submission: - Interviews were conducted by staff member A with residents who resided on resident #99's hallway, with no concerns related to NF3's care or care from other CNAs. - Security camera footage was reviewed and found inconclusive since there was no clear view of resident #99's room entrance. - NF3 resigned her employment prior to the facility completing its findings of the incident. - The facility's interdisciplinary team found there was a lapse in care by NF3 to resident #99, and her employment would have been terminated had she not voluntarily resigned. - Interdisciplinary team findings concluded this was an isolated incident with resident #99, with no evidence of a broader pattern of neglect involving other staff members or residents. A second request was made to the facility on 1/14/26 at 5:10 p.m., for any documentation of interdisciplinary team notes, the event review, staff education or training following the event, and or evidence of the notification of resident #99's provider and responsible party. The facility did not provide additional documentation by the end of the survey. Review of a facility policy titled Abuse, Neglect and Exploitation, implemented 4/11/25, showed: . V. Investigation of Alleged Abuse, Neglect and Exploitation . B. Written procedures for investigations include: . 6. Providing complete and thorough documentation of the investigation. VII. Reporting/Response. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to revise a care plan to reflect a resident's current care needs after an elopement for 1 (#67) of 29 sampled residents. The failure placed the resident at elevated risk for additional elopements. Findings include:Review of the facility's investigation of a Facility-Reported Incident, submitted to the State Survey Agency on 9/27/25, showed resident #67 eloped from the facility without staff knowledge.During an interview on 1/13/26 at 11:03 a.m., staff member A stated resident #67 exited the facility through an alarmed door that had been deactivated by a facility vendor. Staff member A stated resident #67's care plan was updated after the Interdisciplinary Team meeting to include the elopement risk, and interventions to prevent similar events in the future.During an observation and interview on 1/13/26 at 1:22 p.m., resident #67 was lying in bed, looking out the window. Resident #67 stated he did not recall the elopement incident, but stated, I would like to go outside.During an interview on 1/14/26 at 11:22 a.m., staff member C stated care plans are updated by the nurses, herself, or staff members D or E. Staff member C pointed to a stack of papers on her desk, and stated, These are care plans here I am going through. I review them and confirm any care issues with the nurses and then update them as needed.During an interview on 1/15/26 at 9:45 a.m., staff member D stated the care plan updates would occur after an event by herself or staff member E. Staff member D stated care plans could also be updated on an as-needed basis by any of the staff nurses.Review of a facility incident investigation document titled, Reportable Incident - 9/27/25, undated, showed, Findings/Final Determination . Care plan updated to reflect resident's need for closer monitoring and supervision when approaching facility exits.Review of resident #67's care plan showed the following entry dated 9/27/25: . 9/27/25- Resident added to elopement binder and educated that he cannot leave facility without assistance and educated to use the enclosed patio to enjoy the outdoors when desired.Engage Resident in purposeful activity; Identify if there are triggers for wandering / eloping; Identify wandering / elopement de-escalation behaviors; Provide care in a calm and reassuring manner . [sic]The care plan failed to specify the need for closer supervision and monitoring when approaching facility exits, as identified in the facility's Reportable Incident - 9/27/25 incident summary document.Review of a facility policy titled, Elopements and Wandering Residents, latest revision date 4/30/25, showed, . 4. c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff.

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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. Based on the interview and record review, the facility failed to ensure staff responded to resident needs timely for a resident requiring assistance with activities of daily living for 1 (#99) of 29 sampled residents. The deficient practice increased the risk for skin integrity issues. Findings include:Review of a Facility-Reported Incident, dated 6/5/25 at 8:40 a.m., showed staff member O found resident #99 lying in his bed in urine-soaked clothing and a soiled brief. This was discovered by staff members O and L after shift change report was completed with NF3, who was a night shift staff member responsible for resident #99's care.During an interview on 1/15/26 at 12:18 p.m., staff member L stated she was one of the day shift staff members who started providing morning cares for assigned residents on 6/5/25, which included resident #99. Staff member L stated NF3, an off going night shift staff member, provided information in report. Staff member L stated before she left, NF3 did not mention resident #99 needed to have his brief and clothes changed. Staff member L stated she did not know how long resident #99 waited for a staff member to assist him with changing his brief. Staff member L stated if she had been told by NF3 that resident #99 needed his brief changed, she would have gone right away to resident #99. Staff member L stated she did not know why NF3 did not change resident #99's brief, but it was not the normal routine to leave a resident with a soiled brief or clothes.Review of resident #99's Minimum Data Set with a Quarterly assessment reference date of 5/14/25, Section GG - Functional Abilities, showed that GG0130, Self-Care, was coded as 3, for lower body dressing and toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). The 3 code reflected resident #99 required partial/moderate assistance with a staff member to help lift, hold, or support the trunk or limbs, in completing the activities. Section H - Bladder and Bowel, showed that resident #99 had was coded as a 2, as frequently having urinary and bowel incontinence.Review of resident #99's comprehensive care plan showed a problem initiated 3/24/25 for ADL self-care performance deficit . Interventions . INCONTINENCE CARE: Staff should check resident regularly for incontinence episodes and provide prompt peri-care after incontinence episodes . An initial request was made to the facility on 1/12/26 at 12:29 p.m. for documentation of investigation notes to include interviews and findings for the facility reported incident of 6/5/25. The facility provided a pertinent investigation finding of the facility's interdisciplinary team, which included a lapse in care by NF3 for resident #99.