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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51111 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable environment for 1 (#14) of 36 sampled residents. Findings include: During an observation on 11/5/24 at 9:56 a.m., there was a dried, crusty brown substance near an electrical outlet on the wall next to resident #14's bed. There was a visible large amount of white, dried crusted substance on the top blanket of resident #14's bedding. During an observation on 11/5/24 at 2:29 p.m., there was still a dried, crusty brown substance near an electrical outlet on the wall next to resident #14's bed. During an observation on 11/6/24 at 8:52 a.m., there was still a dried, crusty brown substance near an electrical outlet on the wall next to resident #14's bed. There was a dried sticky area of debris on the floor alongside resident #14's bed, which was seen and heard when walking on the section of the floor. The privacy curtain next to resident #14's recliner had dark brown, dried stains on it. During an observation and interview on 11/6/24 at 9:43 a.m., staff member Q observed the sticky floor along resident #14's bed, and the dried crusty, brown substance near an electrical outlet on the wall next to resident #14's bed. Staff member Q stated it might be chocolate pudding. Staff member Q stated she had not noticed the stain when she was changing the resident's bed sheets that morning. Staff member Q stated she thought the curtain looked like it had a food or juice stain on it, when shown the dark brown stains on the privacy curtain in resident #14's room next to his recliner. Staff member Q stated she had not seen curtains in resident rooms changed or replaced before. During an observation and interview on 11/6/24 at 10:32 a.m., staff member J stated she thought the dried crusty brown substance on the wall next to resident #14's bed looked like feces stains. During an observation on 11/7/24 at 9:24 a.m., on the floor beside resident #14's bed, there were new dried crusty brown pieces of a substance on the floor, and there were two new sticky-looking stains on the floor, a light pink stain, and a light brown stain. The privacy curtain next to resident #14's recliner still had dark brown dried stains on it. During an interview on 11/7/24 at 9:35 a.m., staff member U stated housekeeping staff had a daily sheet of resident units to clean. Staff member U stated housekeeping staff was to go into resident rooms and clean, which included sweeping and mopping floors of the rooms. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #14's Care Plan, with a review date of 10/25/24, showed: . The resident is high risk for falls . Intervention: The resident needs a safe environment with floors and seating areas free from spills . The resident has bowel incontinence. Date Initiated: 09/19/2023 A request was made on 11/6/24 for a facility document of a housekeeping duty sheet for cleaning of resident #14's room, for November 2024, but was not received by the end of the survey.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48268 Based on interview and record review, the facility failed to provide written notice of the reason for a facility-initiated transfer to a resident or the resident's representative, for 3 (#s 18, 64, and 78) of 36 sampled residents, and staff were not aware of the process or need for completion of the transfer notices. Findings include: 1. Review of resident #18's medical record showed the resident was transported to the hospital for an acute change in condition on 11/7/23 and 8/19/24. The medical record failed to show the required written notice of the reason for the transfer was provided to the resident or representative. During an interview on 11/6/24, staff member L stated she was unfamiliar with the federal regulation and facility policy for written resident notification of transfer. Staff member L stated, Well, we do tell them they are going to the hospital, and we complete a transfer form for the receiving hospital, but I am unfamiliar with any form or document that needs to be filled out for the residents. A request for transfer notifications for resident #18's hospital transfers on 11/7/23 and 8/19/24 was requested on 11/6/24. No transfer notification documentation was received for the transfers on 11/7/23 and 8/19/23 prior to the end of the survey. 49554 2. Review of resident #64's medical record showed the resident was transferred to the hospital on 9/13/24 for tingling and involuntary movements of the left arm. The medical record failed to show the required written notice of transfer was provided to the resident or representative. During an interview on 11/5/24 at 2:03 p.m., resident #64 stated she did not sign anything when she went to the hospital, and she did not recall receiving any paperwork. A facility request was made on 11/6/24 for notification of transfer discharge for resident #64 and the facility did not provide one by the end of the survey period. 41951 3. Review of resident #78's medical record showed the resident was hospitalized on [DATE], due to a decompensation in condition after a choking incident on 9/4/24. Resident #78 did not return to the facility. A request was made to the facility on [DATE] at 9:42 a.m., for resident #78's written notification of transfer to the hospital. No documentation was provided to the State Survey Agency by the end of the survey. During an interview on 11/6/24 at 2:25 p.m., staff member K stated the facility did not have a notice of transfer for resident #'s 18, 64, or 78. Staff member K stated she could see notice of transfers were not being completed, were a trend, and would need to be addressed. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Discharging/Transferring the Resident, last revised 12/1/19, showed: - . 6. If the resident is being discharged to a hospital, ensure that a discharge/transfer form, medication list, current history and physical, POLST and bed hold notice are reviewed with the resident and/or resident representative prior to discharge to the extent reasonable and practical. A copy of these forms shall be sent with the resident to the hospital. [sic]

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48268 Based on interview and record review, the facility failed to provide the required bed hold notice to the resident or the resident's representatives prior to, or timely after, a transfer, for 3 (#s 18, 64, and 78) of 36 sampled residents. Findings include: 1. Review of resident #18's medical record showed the resident was transported to the hospital for acute changes in condition on 11/7/23 and 8/19/24. There was no documentation in the medical record to show the resident or his representative was provided or notified of the required written bed hold notice. During an interview on 11/6/24 at 2:10 p.m., staff member L stated, I guess I don't know who is responsible for the bed hold documentation or how that (process) works. I have seen them in the record once in a while, but I have never completed one. A request for bed hold notifications for resident #18's hospital transfers on 11/7/23 and 8/19/24 was requested on 11/6/24. No bed hold notification documentation was received for the transfers prior to the end of the survey. 49554 2. Review of resident #64's medical record showed the resident was transferred to the hospital on 9/13/24 for tingling and involuntary movements of the left arm. The medical record failed to show the resident or representative was provided or notified of the required written bed hold notice. During an interview on 11/5/24 at 2:03 p.m., resident #64 stated she did not sign anything when she went to the hospital, and she did not recall receiving any paperwork. 41951 3. Review of resident #78's medical record showed the resident was hospitalized on [DATE] due to a decompensation in condition after a choking incident on 9/4/24. Resident #78 did not return to the facility. A request was made to the facility on [DATE] at 9:42 a.m., for resident #78's written notification of the facility's bed hold policy upon transfer to the hospital. No documentation was provided to the State Survey Agency by the facility. During an interview on 11/6/24 at 2:25 p.m., staff member K stated the facility did not have a notification of the facility's bed hold policy for resident #'s 18, 64, or 78. Staff member K stated she could see the notifications of the facility's bed hold policy were not being completed, were a trend, and would need to be addressed. Review of facility document titled, Bed Hold Notice Upon Transfer, dated 1/1/24, showed the following: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any; c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed; d. Conditions upon which the resident would return to the facility: - The resident requires the services which the facility provides; - The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 2. In the event of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan . Review of the facility's policy titled, Holding Bed Space, last revised 12/06, showed: - Policy Statement - Our facility shall inform residents upon admission and prior to a transfer for hospitalization or therapeutic leave of our bed-hold policy. - Policy Interpretation and Implementation - 1. Upon admission and when a resident is transferred for hospitalization or for therapeutic leave, a representative of the business office or designee will provide written information concerning the facility's bed hold policy. [sic]

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49554 Based on observation, interview, and record review, the facility failed to complete a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences within 14 days of admission for 1 (#233) of 36 sampled residents. Findings include: During an observation and interview on 11/4/24 at 2:10 p.m., resident #233 was observed to have wounds on both legs and the left arm. Resident #233 was eating lunch and her left hand was laying in the food on her plate. Resident #233 stated, I have trouble eating sometimes, but it is getting better. Review of a facility provided document titled Matrix, resident #233 did not trigger for any medical conditions including wounds. Review of resident #233's medical record showed resident #233 was admitted to the facility on [DATE]. The ARD for the completion of the comprehensive admission MDS assessment was 8/22/24. The comprehensive admission MDS assessment was open and showed in progress. This assessment should have been completed and submitted within 14 days of admission to the facility. The comprehensive Admission MDS was 76 days late, as of the last day of the survey period. During an interview on 11/6/24 at 12:34 p.m., staff member D stated initial admission MDS assessments were conducted and submitted within 14 days of admission. As of the end of the survey period on 11/7/24, the comprehensive admission MDS assessment for #233 had not been completed or submitted to CMS.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48268 Based on observation, interview, and record review, the facility failed to accurately complete the Admission Minimum Data Set (MDS) assessment for the resident's oral status, for 1 (#8) of 36 sampled residents. Findings include: During an observation and interview on 11/4/24 at 2:02 p.m., resident #8 was observed to have no natural teeth and no dentures. Resident #8 stated she did not have teeth when she was admitted to the facility, as she had them removed around July of 2024, and had not yet had dentures fitted. Resident #8 stated she was admitted to the facility on [DATE]. During an interview on 11/6/24 at 9:06 a.m., staff member E stated resident #8 did not have teeth on admission to the facility and has had several appointments for denture fittings since her admission. During an interview on 11/6/24 at 2:25 p.m., staff member D stated she was responsible for MDS assessments and was in the process of getting all the resident MDS information updated and accurate. Staff member D stated the MDS assessment involved a comprehensive face-to-face evaluation, including a dental assessment. Review of resident #8's Admission MDS, with an ARD of 9/19/24, section L, showed the resident had no broken or missing teeth.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48268 Based on observation, interview, and record review, the facility failed to implement a comprehensive, resident-centered care plan which identified the resident's physical and psychosocial needs to help the resident reach their highest practicable level, for 1 (#8) of 36 sampled residents. Findings include: During an observation and interview on 11/4/24 at 2:02 p.m., resident #8 was observed to have no natural teeth and no dentures. Resident #8's voice was impaired by the absence of teeth, with difficulty making s and t sounds. Resident #8 stated she was embarrassed by not having teeth, and stated, I feel like people don't like me because I look funny without my teeth, and I am hard to understand. I am supposed to be getting dentures, but it is taking a while because I guess I have some jaw problems. The dentist fitted me a couple of times but so far, no teeth. I am hoping maybe by Thanksgiving. Resident #8 also stated she had some difficulty eating, even with the bite-sized diet the facility was providing. Resident #8 was also observed during this interview to be wearing one hearing aid and was having difficulty hearing. Resident #8 stated, I have no hearing in one ear at all, and wear the hearing aid in the other, but I still need to read lips to understand people most of the time. During an interview on 11/6/24 at 9:07 a.m., staff member E stated resident #8 had a dental appointment on 10/24/24, but did not know the status or outcome of the appointment and called staff member P to ask the status. Staff member E then stated staff member P told her resident #8's next dental appointment was on 11/19/24. During the interview, staff member E was unable to locate information in the medical record on the status of resident's #8's dentures, including whether she had natural teeth on admission. Review of resident #8's care plan, initiated on 9/9/24, failed to show any focus areas related to resident #8's dental, eating, dietary modifications, or hearing difficulties. A request was made on 11/6/24 for dental provider notes. None were received by the end of the survey.

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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. 49554 Based on interview and record review, the facility failed to revise an individualized comprehensive care plan to reflect a mental health diagnosis, for 1 (#233) of 36 sampled residents. Findings include: Review of resident #233's physician's order, dated 10/3/24, showed, Please call to schedule appt with Encounter Telehealth Psychiatry for bipolar disorder, depression. [sic] Review of resident #233's care plan, with an initiation date of 9/3/24, failed to show any information for a Focus, Goals, or Interventions for a diagnosis of bipolar depression. Review of the most recent H&P, dated 1/30/24, showed bipolar depression as an active diagnosis for resident #233. Review of resident #233's medical record, showed the facility submitted a letter requesting a PASARR Level II for resident #233 on 9/13/24, due to a history of bipolar depression. No further documentation was provided by the end of the survey period to show a PASARR Level II was performed. During an interview on 11/6/24 at 12:34 p.m., staff member D stated resident care plans should be completed upon admission, quarterly, or with any change in a resident's condition. Staff member D stated care plans should reflect all current diagnoses for residents. Staff member D stated staff member E conducted PASARR's on residents, and the information from the PASARR should be reflected in the resident's care plan.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 51133 Based on interview and record review the facility failed to employ a qualified activity professional to direct the activity program, which may affect all residents receiving or participating in activities at the facility. Findings include: During an interview on 11/6/24 at 11:52 a.m., staff member F stated she was hired in September (2024), has not completed, and was not currently enrolled in an activities professional training program. Review of staff member F's resume showed she did not meet the minimum qualifications to direct the activity program.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50245 Based on observation, interview, and record review, the facility failed to sufficiently and accurately document pressure ulcers for 3 (#s 11, 57, and 76) of 36 sampled residents. Findings include: a. During an interview on 11/6/24 at 12:16 p.m., resident #57 stated, I'm hurting. Resident #57 had stated she needed to be cleaned up as she had a bowel movement about 30 minutes ago. Review of resident #57's EHR showed Morphine Sulfate 20 mg/mL and Tramadol 50 mg was available PRN. During an observation and interview on 11/6/24 at 12:25 p.m., resident #57 had a previous 4x4 optifoam dressing and a wound to her coccyx. Staff member M stated she did not have this wound a month ago when staff member M last saw resident #57. When asking both staff members what the redness and raised bumps were to resident #57's right thigh, staff member J stated they would have to check with the nurse as they did not typically work on this wing. Staff member M stated they thought it looked like a rash. Staff member M stated they had seen slight redness to this area the last time they worked with resident #57, but stated it was nothing like this. When asked how long the coccyx wound had been present, staff member J stated they would need to follow up with the surveyor, but this did not occur. Review of resident #57's EHR showed a nursing note on 11/6/24 at 3:35 a.m., .Will enter in PCC as wound order until further advised . [sic]. Review of resident #57's EHR showed no wound assessments completed. Review of resident #57's EHR showed a coccyx wound care order started on 11/6/24, which was after staff member J had been asked about the wound order for #57. During an interview and return phone call that was initially placed on 11/7/24 at 8:57 p.m., NF1 stated resident #57 had the pressure sore on her buttock for more than six weeks. NF1 stated the facility had been putting a cream on the buttock area, which did no good. NF1 stated they often visited resident #57 and she was in the same position or in a position that was painful to her. NF1 stated resident #57 often told them her buttock hurt from sitting. NF1 stated she had visited the day prior, and they felt resident #57 was in the same position that day, which was laying on her left side. NF1 stated they felt resident #57's brief was not changed often enough, and they felt this was why resident #57 developed an open area wound on her coccyx. During an interview on 11/6/24 at 1:34 p.m., with staff member C, pertaining to why weekly skin assessments and wound assessments were different on the same day, or around the same period of time, staff member C stated weekly skin assessments should also encompass any pressure ulcer if it was applicable. Staff member C stated education may be needed for wound documentation /care. During an interview on 11/6/24 at 2:16 p.m., staff member B stated they were unsure why resident #57's wound had not been documented on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Review of resident #11's Weekly Skin Check Assessment, in the EHR, dated 10/13/24, showed: .skin is intact. Review of resident #11's Wound - Weekly Observation Tools, dated 10/10/24 and 10/17/24, showed: a right lateral ankle Stage 4 pressure ulcer. c. Review of resident #76's Weekly Skin Check Assessment, dated 10/10/24, showed: .skin is intact. Review of resident #76's Wound - Weekly Observation Tool, dated 10/10/24, showed a Stage 4 pressure ulcer to the coccyx. Review of resident #76's TAR showed six missed wound care sessions for the Stage 4 pressure ulcer on her coccyx, which was on the following dates: 10/6/24, 10/12/24, 10/13/24, 10/14/24, 10/18/24, and 10/22/24. Review of resident #76's physician order, with a start date of 9/27/24, and an end date of 10/22/24, showed: Wound Orders: . every day shift for Stage III pressure. [sic] Review of resident #76's TAR showed one missed care for the Stage 4 pressure ulcer on her coccyx on 11/2/24. Review of resident #76's physician order with a start date of 10/22/24, showed: Stage IV PU coccyx - clean . every day . [sic] Review of resident #76's EHR showed no Weekly Skin Assessment was completed from 10/13/24 to 10/19/24. Review of resident #76's Weekly Skin Assessment, dated 10/10/24, showed a blank assessment. Review of a facility provided document, titled Wound Care, revised 10/2010, showed: .Documentation: The following should be recorded in the resident's medical record after providing wound care: 1. The type of wound care given. 2. The date and time the wound care was given. 3. Any change in the resident's condition. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the treatment and the reason(s) why. 6. The name and title of the person recording the data .

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F 0689 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51111 Based on observation and interview, the facility failed to ensure the safe storage of chemicals in an unlocked closet on the Rosebud unit hallway, and this increased the risk of resident misuse of the chemical due to the closet being unlocked. Findings include: During an observation on 11/6/24 at 3:50 p.m., along the hallway on the Rosebud unit, a housekeeping closet door was closed. The door was unlocked, and the surveyor was able to open the door without the use of a code or key, to enter. There were three chemical containers with hoses, all labled with an Ecolab label. Each had posted warnings and first aid precautions displayed on the container labels. During an observation and interview on 11/7/24 at 8:43 a.m., staff member V stated the housekeeping and janitor supply closets were supposed to be locked when the door was closed and staff were not in the area. Staff member V stated the door was supposed to lock, with a code to open the door, but the door could be opened with a key too. After the interview, staff member V left the Rosebud unit housekeeping closet and closed the door. Upon observation, the door was unlocked without requiring the use of a code or key to enter. The hallway next to the housekeeping closet was observed to have residents passing by as they entered other areas of the building. During an observation and interview on 11/7/24 at 9:40 a.m., staff member U stated the doors to the housekeeping and janitor closets, which contain cleaning supplies, cleaning carts, and chemicals, were to be locked and closed when staff were not in the closet getting supplies. Staff member U observed the door to the Rosebud unit hallway housekeeping closet was able to opened without a code or the use of a key. Staff member U stated the door would lock, but the door was not shutting all the way into place, when closed. Staff member U stated they would let maintenance staff know about the door not closing completely, and submit a maintenance request, to ensure the storage room door lock engaged properly. A request was submitted for documentation or policies on Housekeeping or Maintenance Rooms, and securing them, on 11/7/24, but nothing was received by the end of the survey.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 50245 Based on observation, interview, and record review, the facility failed to follow physician orders, for 2 (#s 3 and 20); failed to follow enhanced barrier precautions for 1 (#20); and failed to measure and record the total fluid volume administered for 2 (#s 3 and 20) of 2 sampled residents with a PEG tube. Findings include: 1. During an interview and observation, on 11/6/24 at 9:16 a.m., staff member H was administering medications to resident #3 through a PEG tube. Staff member H measured the individual fluid amounts, but was not observed to write down a final total fluid volume. During the medication administration, staff member H had given a -30 mL (initial flush) of water. Staff member H stated she felt resistance when flushing #3's PEG tube, but stated this was normal. Staff member H stated she had held the tube feed prior to the medication administration, as resident #3 had not been tolerating the tube feeds. Staff member H was observed to administer fluid amounts of: -15 mL (with medications) -15 mL -15 mL (with medications) -15 mL -15 mL (with medications) During an observation on 11/6/24 at 9:23 a.m., staff member H noticed #3's PEG tube moved out from its original location, and then pushed the flange down to be flush with resident #3's stomach, which left the tube out more than where it had originated. Staff member H stated this happened often with this resident. Staff member H did not check for placement after the PEG tube for #3 had moved. Staff member H changed the tip of the syringe as it was felt this was the reason there was resistance when administering the medications and the water. Staff member H continued giving the following amounts of water: -15 mL -35 mL (with medications) -30 mL Review of resident #3's EHR showed the following physician's order: Flush tube with 15-30 CC's of water before and after medication administration. Flush with 5-10 cc's in between each medication. [sic] (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #3's MAR showed nine medications were administered via the Peg tube. It was observed that a total of at least 185 mL of water was put into the PEG tube. Following the physician's order, and with the nine medications administered, the maximum amount of water that should have been administered would be 150 mL. Review of resident #3's TAR showed a total of 60 mL of fluid was documented by staff member H on 11/6/2, which was not what was observed. 2. During an interview on 11/4/24 at 3:35 p.m., resident #20 stated his medications were administered through his PEG tube, and they were frequently given late. He described the issue of how late meals and late medications led to him not being hungry at the appropriate times. Resident #20 stated when the meals were served at 10:00 a.m., and the medications were administered at 11:30 a.m., he was not hungry for his lunch meal. Review of resident #20's EHR showed resident #20's weight was 137 pounds on 6/22/24. Resident #20's weight on 10/30/24 was 121 pounds. During an interview on 11/6/24 at 10:06 a.m., staff member J stated hand sanitization was expected to be completed after removing gloves and prior to coming out of a resident's room. Staff member J also stated enhanced barrier precautions (EBP) needed to be adhered to when cares were completed with a resident who had a wound, tube feed (PEG tube), or a Foley catheter. During an observation and interview on 11/6/24 at 10:07 a.m., resident #20 stated breakfast was served at 9:30 a.m. When asked if he had gotten his medications yet this morning, resident #20 stated, No, that's not unusual. Review of resident #20's MAR showed eight medications (given via PEG) were scheduled for 6-10a. (6:00-10:00 a.m.) [sic] During an interview on 11/6/24 at 12:06 p.m., staff member N stated the facility expected staff members to document a total fluid volume for medication administration for PEG tubes. During an observation and interview on 11/6/24 at 1:01 p.m., staff member N had a half-crushed pill of Zofran in a medication cup that was prepared for a PEG tube medication administration. Staff member N stated this would be okay as the water would dissolve this medication. It was observed staff member N had used cold water. A large amount of crushed iron was observed remaining in the package used to crush the medication, and when asked about the medication remaining the package, staff member N then moved the rest of the medication from the package to the medication cup. During an observation on 11/6/24 at 1:06 p.m., staff member N went in and out of resident #20's room several times without removing her gloves or completing proper hand hygiene. Enhanced barrier precautions were not followed. During an observation on 11/6/24 at 1:07 p.m., staff member O asked if resident #20 was ready for his lunch. Resident #20 sighed, and he expressed he would not be very hungry because he was just getting his medications. He asked staff member O to bring his food in later. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/6/24 at 1:08 p.m., staff member N stated the medications could not be mixed as there was not a physician's order for that. Staff member N poured an unmeasured amount of water into nine different cups which contained the eight scheduled medications. Staff member N did not complete hand hygiene, and staff member n did not remove gloves the three times, prior to leaving the room to obtain nine spoons. Review of resident #20's MAR and TAR showed the following physician orders: - Enteral Feed Order every shift check placement/patency before and after giving medications and starting feedings. - Enteral Feed Order every shift flush tube with 30 - 50 cc pre and post medication administration via tube. - Enteral Feed Order every shift may crush/combine medications for administration if not contraindicated and mix with 4 ox of water . [sic] -Enhanced Barrier Precautions: PPE requiredfor high resident contact careactivities. [sic] During an observation and interview on 11/6/24 at 1:15 p.m., staff member N did not check the placement of the PEG tube for resident #20, prior to starting medication administration, and staff member N did not flush the PEG tube prior to or after the medications were administered. Staff member N poured one medication after the other into the tube, using gravity force, without flushing between the medications per the physician's order. Staff member N was not observed to measure the total fluid volume administered. A substantial amount of medication was left in the bottom of one medication cup. Review of resident #20's TAR showed staff member N signed off on the PEG tube placement prior to giving medications on 11/6/24. During an interview on 11/6/24 at 1:28 p.m., resident #20 stated, Now with the late eggs and all the meds in me. Now I'm full. Resident #20 stated he did not want lunch.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 48268 Based on interview and record review, the facility failed to complete a trauma-informed assessment to identify, manage, avoid potential triggers, and maintain the highest practicable well-being, for 1 (#8) of 1 resident with a diagnosis of post-traumatic stress disorder (PTSD). Findings include: During an interview on 11/4/24 at 2:02 p.m., resident #8 stated she did have a PTSD diagnosis related to so much abuse. Resident #8 stated she gets nightmares pretty regularly, and stated no one from the facility had talked to her about her PTSD since she was admitted . During an interview on 11/6/24 at 4:10 p.m., Staff member K stated she did not think a trauma informed assessment was necessary for resident #8, as the PTSD diagnosis was not included in the PASARR Level II evaluation, and the PTSD was not an active diagnosis. Review of resident #8's PASARR Level II evaluation, dated 10/22/24, showed resident #8 had a history of abuse as a child that still affected her. Review of a psychiatric telehealth note, dated 10/30/24, showed resident #8 was seen for an initial consultation for the treatment of PTSD. A request was submitted for #8's facility trauma-informed assessment on 11/6/24. Trauma-informed assessment documentation was not received prior to the end of the survey.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 51133 Based on interview and record review, the facility failed to assure the Director of Nursing did not work as a charge nurse when the average daily census was more than 60 residents, which may negatively affect any resident. Findings include: Review of the facility nursing schedules showed staff member B was scheduled to work as charge nurse on the following days: . 4/27/24 on day shift from 6-12 . 4/28/24 on day shift from 3-6 . 10/4/24 on night shift from 10-6 Review of the [Facility Name] Daily Nursing Staff Posting and Census showed the census on 4/27/24 was 69, on 4/28/24 the census was 69, and on 10/4/24 the census was 76. Review of a Facility Assessment Tool, Date(s) of assessment or update 9/26/24 - 10/17/24, showed, . Part 1: Our Resident Profile . 1.2. Indicate your average daily census: (enter a range) _ 74.5_. [sic] During an interview on 11/7/24 at 8:53 a.m., staff member B stated, This last week and half I had to work on the floor more, but this was the last week. The facility was going to hire two more nurses, then I should not have to work the floor (as a charge nurse).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51111 Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled and stored; failed to properly dispose of expired medications; failed to ensure medication carts were locked when staff was not by them; and failed to monitor medication refrigerator and freezer temperatures. These failures could negatively affect a resident receiving improperly stored or expired medications, or from the refrigerator or freezer if temperatures were not maintained in a safe manner. Findings include: During an observation on 11/6/24 at 10:48 a.m., a medication cart had scattered loose pills on the top shelf where stock medication bottles were stored. The medication cart had the following opened and undated medication containers and bottles: - Stool softener docusate 100 mg, - Vitamin B Complex, - Zinc 50 mg, - Folic Acid 1000 mcg, - Senna 8.6 mg, - Aspirin 325 mg, - Milk of Magnesia opened with a date of 6/3/24, and - Mylanta opened with a date of 7/5/24. During an interview on 11/6/24 at 10:52 a.m., staff member L stated when staff opened over the counter bottles of medication, they needed to write the date on them. Staff member L stated medication bottles like Mylanta and Milk of Magnesia were supposed to be changed out within 30 days after being opened. Staff member L confirmed an expiration date of 10/2024 on a nasal spray labeled Fluticasone. The nasal spray had an opened date of 3/5/24 written in black marker and the expiration date was partially covered over by the writing from the black marker. During an observation on 11/6/24 at 3:14 p.m., the Rosebud unit medication room refrigerator had no temperature logs displayed. The medication room sink had an oval yellow pill labeled '251' in it. During an observation on 11/6/24 at 3:27 p.m., a medication cart was left unattended, with medication cards on the top of the cart. Staff member H walked to the medication cart from a room after it was unattended for about a minute. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 3:28 p.m., staff member H stated, I don't leave pills alone on the cart. I left this card out because the medication was discontinued and to remind myself about it, but I thought the lab lady was still right by in the hallway watching the cart. Staff member H was handed a silver capsule container labeled Handihaler Device, Do Not Swallow that had been lying on the floor outside of a room. Staff member H stated, Thank you, this one is empty though, it doesn't have any capsules in it. During an observation on 11/6/24 at 3:59 p.m., a medication cart was unattended outside of a room in a hallway with the cart unlocked. The nearest nurse staff member N was seen down the hallway out of view in an alcove, talking on a cell phone. Three residents were observed passing along in the hallway by the medication cart. A request from 11/6/24 and 11/7/24 of facility documents for medication refrigerator temperature logs for Rosebud and TCU units for July - October 2024 were not provided by the end of the survey. Review of a facility document labeled, Night shift nurse(s) duties that must be done every night, showed, . check fridge temps in the med room and the nutrition room. There are sheets to record the temps on for the fridge/freezer . [sic] Review of a facility policy titled, Refrigerators and Freezers, adopted December 2016, showed: This facility will ensure safe refrigerator and freezer . temperatures, and sanitation . 1. Acceptable temperature ranges are 35 to 41 degrees Fahrenheit for refrigerators and less than 0 degrees Fahrenheit for freezers . 2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. 3. Monthly tracking sheets will include date, temperature, initials of person performing temperature check, and action taken for any out of range temperatures. 4. Food Service Manager or designated employee will check and record refrigerator and freezer temperatures daily. 5. The supervisor will ensure immediate action has been taken if temperatures are out of range. Actions necessary to correct the temperatures will be recorded on the tracking sheet . Review of a facility policy titled, Medication Labeling and Storage, not dated, showed: The facility stores all medications . in locked compartments . the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . compartments (including . carts) containing medications . are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others . 1. Labeling of medications . is consistent with applicable federal and state requirements . 2. The medication label includes, . medication name . prescribed dose; strength; expiration date . resident's name; route of administration; and appropriate instructions and precautions . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For over the counter (OTC) medications in bulk containers . the label contains . medication name; strength; quantity; lot number; and expiration date . only the dispensing pharmacy may label or alter the medication container or package .

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50245 Based on interview and record review, the facility failed to provide dental services for 1 (#17) of 36 sampled residents. Findings include: During an interview on 11/4/24 at 2:36 p.m., resident #17 stated she felt she had a cracked wisdom tooth. Resident #17 stated she was not aware of an appointment made for her, but she had told many of the staff about her tooth concerns. When asked, resident #17 stated staff have not asked her if she needed dental, hearing, or eye appointments regularly scheduled. During an interview on 11/7/24 at 9:26 a.m., staff member E stated they were aware of resident #17's need for a dental cleaning appointment, but they were not aware of an issue concerning resident #17's wisdom tooth. Staff member E stated the appointment had been communicated to staff member P, as staff member P made the appointments. When staff member E looked for the scheduled appointment, and the communication text to staff member P, staff member E was unable to find the information. Staff member E stated they must have told staff member P verbally that resident #17 needed a dental appointment. When asked how appointments were tracked or how staff member E knew the appointment was completed, staff member E stated they did not have a system, and it would be possible for a resident to fall through the cracks. When asked if staff member E regularly documented their meetings with the residents, they stated they did not document each meeting and was currently behind in the quarterly meetings. When asked if staff member E specifically asked residents about a potential need for dental appointments, staff member E stated no, they did not specifically ask residents. Review of resident #17's EHR showed the last documented note from staff member E was on 4/24/24 regarding specialty appointments.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49554 Based on observation, interview, and record review, the dietary department failed to have sufficient staffing to safely and effectively carry out the functions of the food and nutritional services department, by serving meals cold and late. This failure may negatively affect any resident receiving services from the dietary department. Findings include: During an observation and interview, on 11/4/24 at 12:16 p.m., staff member S was serving trays to residents in the dining room. Staff member S stated, I would walk around with you, but I am in the middle of serving. A dietary staff member showed the surveyor where the dry storage was kept, and stated, We are so short staffed. Why is it so hard to get people to work nowadays? Review of a facility document titled, Yellowstone Dining Room Meal Service Times, showed: Breakfast 7:45 a.m. Lunch 11:45 a.m. Dinner 4:45 p.m. During an observation on 11/05/24 at 8:01 a.m., residents were in the dining room waiting to be served breakfast. During an observation on 11/05/24 at 8:15 a.m., residents were still in the dining room waiting to be served breakfast. During an observation on 11/05/24 at 8:26 a.m., dietary staff started serving breakfast to the residents in the dining room. During an observation on 11/06/24 at 8:02 a.m., residents were observed in the dining room waiting for breakfast to be served. During an observation on 11/06/24 at 8:14 a.m., dietary staff started serving breakfast in the dining room. During an interview on 11/06/24 at 9:26 a.m., staff member S stated the facility just hired one dietary staff member, but they were still having issues within the dietary department. Staff member S stated, We have had a lot of people out sick, and we had some just quit. During an observation on 11/06/24 at 12:45 p.m., resident #233 was set up in their room for lunch and had not been served yet. During an observation on 11/06/24 at 12:47 p.m., residents were finishing eating in the dining room. Dietary staff were filling hot carts for room delivery. Rosebud Hall was served at this time. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/06/24 at 12:59 p.m., dietary staff were serving Yellowstone Hall room trays for the lunch meal. During an observation on 11/07/24 at 8:40 a.m., residents were eating in the dining room, and the dietary department was starting to prepare room trays. During an observation and interview on 11/07/24 at 8:56 a.m., staff member S was preparing a room tray. Staff member S checked the temperature of the sausage on the tray, and it was at 106 degrees Fahrenheit. Staff member S stated, That is not a good temperature for sausage. It should be warmer than that. During an observation on 11/7/24 at 9:03 a.m., dietary staff were delivering room trays to Yellowstone Hall. During an interview on 11/07/24 at 9:36 a.m., staff member S stated, . I live over an hour away, and we had a call off on a Saturday. The cook never showed up, and I couldn't get here in time to cook breakfast, so the facility management decided to buy pancake platters for all the residents. Meals have been being served late by 30 minutes or more for longer than a month. There is just too much to do for just one person.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49554 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards by failing to label and date food stored in the facility's walk-in cooler and nutrition room refrigerators; failed to prevent or clean dirty surfaces in the walk-in cooler; and failed to maintain or complete routine monitoring of refrigerators and freezers on the Rosebud Hall, which could negatively affect any resident receiving services related to, or foods from, the equipment or areas of concern identified. Findings include: 1. During an observation on [DATE] at 12:16 p.m., the following were observed in the walk-in cooler: - Cheese slices wrapped in plastic wrap, not labeled or dated. - Cool whip opened with no date on it and not covered. - A square tub of red liquid, no label or date on it. - Walk-in cooler floors had splatter marks and debris on them. - The bottom shelves in the walk-in cooler had spill marks and debris. During an observation on [DATE] at 7:32 a.m., a tub of fluid with chunks of fruit were observed in the walk-in cooler, with no label or date, and an undated/covered container of watery rice with vegetables. During an interview on [DATE] at 9:26 a.m., staff member S stated, I think the rice is chicken soup that did not turn out. I am waiting for the other cook to come in so I can ask about it before I throw it out. The fruit is leftover and should have been thrown out. We usually go through the walk-in cooler on Mondays and discard all items that are not marked or that are past their use by date. We go by the first in, first out method and label items for seven days out once it is opened. All items should be labeled and dated with the date it was prepared or opened, and then 7 days out for the discard date. The dietary aides oversee the nutrition rooms. During an observation on [DATE] at 9:59 a.m., a black personal lunch box was observed in the nutrition refrigerator on the Yellowstone Hall. There were two containers of open chip dip dated [DATE] in the bottom drawer of the refrigerator. There was a carafe of yellow liquid on the counter, with no label or date on it. Dried noodles and vegetables which appeared to have mold on them were observed in the sink drain. During an observation and interview on [DATE] at 9:44 a.m., staff member S stated the soup in the nutrition room on Yellowstone Hall was the same as the rice in the walk-in cooler. Staff member S stated, I do not know why it is in there; we never put things like that in the nutrition rooms. They also must have put the seven days out date after they put it in the new container. The dates are wrong, and it needs to go to the trash. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on [DATE] at 8:04 a.m., the red liquid in the tub in the walk-in cooler was still not labeled or dated, the fruit in the water substance was still not labeled or dated, and the floors and bottom shelves in the walk-in cooler was still soiled with spill marks and debris. Review of a facility document titled, Food Receiving and Storage, with an adopted date of [DATE], showed: . Policy Interpretation and Implementation: The Food Services department is responsible to maintain clean food storage areas at all times. 8. All foods stored in the refrigerator or freezer will be covered, tabled and dated with an appropriate use by date, if different than the expiration date on the original container. Such foods will be rotated using a first in-first out system. 14. Food items and snacks kept on the nursing units must be maintained as indicated below: . b. All foods belonging to residents must be labeled with the resident's name, the item and the use by date. f. Partially eaten food may not be kept in the refrigerator. 51111 2. During an observation on [DATE] at 9:57 a.m., inside the Rosebud unit resident food refrigerator door, the bottom shelf, and a side of the bottom drawer had several light brown, sticky substances. The thermometer was lying with its face turned against a side of a shelf, stuck to the side in a light red, sticky substance. During an observation on [DATE] at 9:57 a.m., the Rosebud unit, resident food refrigerator, had the following items: - a cold brew coffee can open and unlabeled, - an opened and unlabeled bottle of diet Pepsi, - an open and unlabeled bottle of Brisk iced sweet tea, - two Yoplait harvest peach yogurts with a use by date of [DATE], - a plastic flatware square container labeled '[resident name and resident room]' with no date with food inside that looked like soup, - two styrofoam containers covered in aluminum foil in a plastic bag labeled '[name] call in date [DATE],' - unlabeled plastic container with red liquid labeled '[name]' with no date, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- a plain cream cheese container with a use by date of [DATE]. During an interview on [DATE] at 10:02 a.m., staff member Q stated she didn't know if dietary or nursing was supposed to check the refrigerator temperatures to log them. She stated the employees had a break room for their foods and juices to go in. Staff member Q stated the refrigerator on the unit was for resident food only. During an observation on [DATE] at 10:05 a.m., the Rosebud unit resident food refrigerator door had a document labeled, Refrigerator & Freezer Temperature Log, for the month of [DATE], and showed no recorded temperature dates for [DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and [DATE]. During an observation on [DATE] at 10:16 a.m., a brown paper bag, on the shelf in the refrigerator, labeled Taco Bell, was dated [DATE]. During an observation on [DATE] at 10:18 a.m., on a shelf in the refrigerator, an unlabeled and undated glass tray of food in a plastic bag had what looked like chicken and mashed potatoes. The glass tray was covered with aluminum foil. During an interview on [DATE] at 10:21 a.m., staff member O stated, Dietary staff, no nurses, are supposed to check the unit's resident food refrigerator temperatures and for cleaning, and later stated, It's both nurses and dietary responsibility for cleaning the fridges. During an observation on [DATE] at 3:14 p.m., staff member C observed the Rosebud unit resident food refrigerator had a thermometer lying in a sticky, dark red substance in which the thermometer had to be pulled up from to display its face. Staff member C observed the expired yogurts and open unlabeled drinks in the refrigerator. During an interview on [DATE] at 3:14 p.m., staff member C stated nurses and dietary staff checked unit refrigerator temperatures. Staff member C stated the food items in the refrigerator looked like a lot of food was brought in over the weekend, and saw it needed cleaning. Staff member C stated, I will take care of that. During an interview on [DATE] at 10:22 a.m., staff member U stated it was dietary staff's responsibility for resident food refrigerator cleaning. Review of a facility document labeled, Rosebud Refrigerator Temperature Log, for the month of [DATE], showed temperatures outside of the acceptable refrigerator temperature range of ,d+[DATE] degrees Fahrenheit on 31 days. Review of a facility document labeled, Rosebud Refrigerator Temperature Log, for the month of [DATE], showed temperatures outside of the acceptable refrigerator temperature range of ,d+[DATE] degrees Fahrenheit on 30 days. Review of a facility document labeled, Rosebud Refrigerator Temperature Log, for the month of [DATE], showed no written temperatures for ,d+[DATE], ,d+[DATE], and ,d+[DATE]. The log showed temperatures outside of the acceptable refrigerator temperature range of ,d+[DATE] degrees Fahrenheit on nine days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a facility document labeled, Night shift nurse(s) duties that must be done every night, showed, . check fridge temps in the med room and the nutrition room. There are sheets to record the temps on for the fridge/freezer . [sic] Review of a facility policy titled, Food Receiving and Storage, adopted [DATE], showed: - 1. The Food Services Department is responsible to maintain clean food storage areas at all times. - All foods stored in the refrigerator or freezer will be covered, labeled and dated with an appropriate 'use by' date, if different than the expiration date on the original container. - Refrigerated foods must be stored below 41F unless otherwise specified by law. - Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements. - Food items and snacks kept on the nursing units must be maintained as indicated below: - All food items to be kept below 41F must be placed in the refrigerator located at the nurses' station and labeled with a 'use by' date. - All foods belonging to residents must be labeled with the resident's name, the item and the 'use by' date. - Refrigerators must have working thermometers and be monitored for temperature according to state-specific guidelines. - Beverages must be dated when opened and discarded after twenty-four (24) hours. Other opened containers must be dated and sealed or covered during storage. - Partially eaten food may not be kept in the refrigerator. Review of a facility policy titled, Refrigerators and Freezers, adopted [DATE], showed: - This facility will ensure safe refrigerator and freezer . temperatures, and sanitation, and will observe food expiration guidelines. 1. Acceptable temperature ranges are 35 degrees to 41 degrees for refrigerators and less than 0? for freezers . 2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. 3. Monthly tracking sheets will include date, temperature, initials of person performing temperature check, and action taken for any out of range temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Food Service Manager or designated employee will check and record refrigerator and freezer temperatures daily. 5. The supervisor will ensure immediate action has been taken if temperatures are out of range. Actions necessary to correct the temperatures will be recorded on the tracking sheet. 6. All food shall be appropriately dated to ensure proper rotation by expiration dates. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and 'use by' dates indicated once food is opened. 7. Food service manager will be responsible for ensuring food items in . refrigerators, and freezers are not expired or past perish dates. 9. Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50245 Based on observation, interview, and record review, the facility failed to follow appropriate infection control practices which included: proper hand hygiene for 4 (#s 3, 11, 17, and 20); proper use of isolation masks; disinfecting equipment after use; environmental cleanliness for 1 (#14); enhanced barrier precautions for 1 (#20); and dietary infection control of 36 sampled residents. Findings include: 1. Hand Hygiene During an observation on 11/6/24 at 9:38 a.m., staff member I and staff member Q were changing a brief for resident #3, who was to receive medication administered via tube feeding after the brief change. Staff members I and Q did not change gloves or use hand hygiene after removing the dirty brief and before putting a clean shirt on the resident. The shirt covered the feeding tube site on resident #3's abdomen. During an interview on 11/6/24 at 9:50 a.m., staff member I stated there were usually glove boxes on the walls in a resident's room. She stated she will grab a pair of gloves from the box, and lay a clean pair on the bed, when changing a resident's brief. Staff member I stated, Oops, I forgot to use some (hand sanitizer) and change gloves, after changing resident #3's brief and putting a clean shirt on the resident. During an interview on 11/6/24 at 10:06 a.m., staff member J stated the facility expected staff to use proper hand hygiene when entering and exiting rooms, and after doffing gloves. During an observation on 11/6/24 at 11:34 a.m., staff member N was preparing medications for resident #11, popped the medications into her ungloved hand, then dropped the medications into the medication cup. Staff member N was observed to handle medications multiple times throughout the survey with ungloved hands. During an observation, of an enteral medication administration, on 11/6/24 at 1:06 p.m., staff member N went in and out of resident #20's room several times without doffing gloves or completing proper hand hygiene. Staff member O had previously been handling enteral medications for resident #20 prior to exiting the room with gloved hands. During an observation on 11/6/24 at 2:43 p.m., staff member R walked in and out of resident #17's room with gloved hands. No hand hygiene was performed. Staff member S had touched the garbage bag and cleaning supplies located outside of resident #17's room as well as multiple surfaces in resident #17's room. During an interview on 11/7/24 at 10:12 a.m., staff member S relayed employement at the facility had been about a month, and staff member S had not received any education on hand hygiene. The last time staff member S could recall had hand hygiene education, was four years ago, but it was at another facility. 2. Isolation Mask Use (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 11/6/24 at 7:41 a.m., staff member N touched the mask used to cover the mouth/nose mask multiple times, then returned to preparing medications for residents. Staff member N's mask remained underneath the nose multiple times throughout the survey. During an observation on 11/7/24 at 9:30 a.m., after the facility was declared to be in COVID-19 outbreak status, staff member W was observed walking down the hallway past the Rosebud nursing station towards a resident hallway, not wearing an isolation face mask. 3. Equipment Sanitization During an observation on 11/6/24 at 11:55 a.m., staff member C removed the medication cart cord from the floor and placed it on the top of the desk without cleaning or disinfecting the cord. During an observation and interview on 11/6/24 at 12:51 p.m., staff member N removed a glucometer from a glove, with resident #18's name on it, and placed it back in resident #18's designated box. When asked if the glucometer was cleaned prior to placing it in the box, staff member N stated the glucometers were cleaned off after every shift, because they were in separate bins for each resident. 4. Enhanced Barrier Precautions During an observation, of an enteral medication administration on 11/6/24 at 1:06 p.m., staff member N did not follow enhanced barrier precautions for resident #20, only gloves were worn by staff member O. Refer to F693 for Tube Feeding. 5. Dietary Infection Control During an observation and interview on 11/6/24 at 8:04 a.m., staff member S stated the dietary staff were accidentally locked out of the kitchen that morning. Staff S stated, I was in a car accident last night and had to be here this morning. Staff member T had open wounds on the arms and hands. Staff member T had gloves on and began serving breakfast. During an observation and interview on 11/6/24 at 9:26 a.m., staff member S was observed serving breakfast with open wounds, not covered, on the arms, and there were open wounds on the employee's hands, which were only covered by a glove. Staff member S stated, I have been to one meeting about infection control, and I think there is training in RELIAS (online training system). The protocol for dietary staff that have wounds would be to wash them and then bandage them and use gloves. The wounds should be covered. I looked in the emergency kit for the dietary department, and there wasn't anything in there I could use to cover them. I asked someone to bring me bandages this morning, and they haven't brought me anything yet. During an interview on 11/6/24 at 9:48 a.m., staff member A stated he understood the concerns for the infection control concerns in the dietary department, and would send a nurse to the dietary department to address these concerns. Review of staff members S's personnel record found there was no infection control training in his record. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A request was made on 11/6/24 for an infection control policy for the dietary department, including safe handling of food. Staff member K stated they do not have a policy that covers dietary infection control and safe handling of foods. During an interview on 11/6/24 at 3:41p.m., staff member D stated audits were completed every two to three weeks to ensure staff were donning and doffing PPE appropriately, in addition to following the enhanced barrier precautions, when necessary. Staff member D stated they did not have a form showing verification of the audits. Staff member D stated enhanced barrier precautions should be followed for anything creating an artificial opening into the body, this included catheters, wounds, and enteral nutrition or enteral medication administration. Staff member D stated hand hygiene education was provided to all staff when they were hired, and an inservice was completed in August. Staff member D stated they provided education, but they did expect staff to come to them if they do not know about a certain topic regarding infection control. When asked if a staff member is noncompliant, but was uneducated in the subject, staff member D stated this would be an example where this staff member would then need to be educated. When asked if staff member D completed audits or observations of infection control in the kitchen area, staff member D stated, I do not. Staff member D stated the dietician would complete that responsibility in the kitchen. 6. Environmental Cleanliness During an observation on 11/5/24 at 9:56 a.m., on 11/5/24 at 2:29 p.m., and 11/6/24 at 8:52 a.m., there was a dried, crusty brown substance near an electrical outlet on the wall next to resident #14's bed. On 11/6/24, there was a dried sticky debris on the floor alongside resident #14's bed, which was visible and heard when walking on the section of the floor. During an observation and interview on 11/6/24 at 9:43 a.m., staff member Q observed the sticky floor along resident #14's bed, along with the dried, crusty brown substance on the wall next to resident #14's bed. Staff member Q stated the substance might be chocolate pudding, and she had not seen the stain on the wall when changing resident #14's bed sheets earlier. During an observation on 11/7/24 at 9:24 a.m., on the floor beside resident #14's bed there were new dried, crusty brown pieces of a substance on the floor, and there were two new sticky-looking stains on the floor, a light pink stain and a light brown stain. During an interview on 11/7/24 at 9:35 a.m., staff member U stated housekeeping staff had a daily sheet of resident units to clean. Staff member U stated housekeeping staff were expected to go inside resident rooms and clean daily, which included sweeping and mopping floors. Requests were made on 11/6/24 and 11/7/24 for facility documents or policies on Hand Hygiene, Peri Care, and a housekeeping duty sheet for cleaning of resident #14's rooms for November 2024, but these items were not received by the end of the survey.

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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.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50245 Based on observation, interview, and record review, the facility failed to timely fix items in resident's rooms for 2 (#s 17, and 44) of 36 sampled residents; and failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff in the Rosebud nursing unit area of the building. Findings include: During an interview on 11/4/24 at 2:51 p.m., resident #44 stated the curtains in his room were broken for over a year. Resident #44's curtains were not able to twist which would allow for more or less light to come in through the window. Resident #44 stated the ability to have functional curtains would be beneficial. During an interview on 11/4/24 at 2:36 p.m., resident #17 stated her windowsill was broken forever. Resident #17 stated she had been in the facility for over two years and the windowsill was broken when she had moved in. Resident #17 stated she had told many staff members about this issue. During an interview and observation on 11/6/24 at 11:41 a.m., staff member G stated other staff members would text staff member G through the WhatsApp or write maintenance requests in the maintenance book. When looking at the maintenance book with staff member G, there were three maintenance requests. One had been completed, but did not have a completion date until staff member G wrote one in at this time. The other two maintenance requests did not address resident #44's, resident #11's, or resident #17's concerns. Staff member G stated they needed to do better about documenting maintenance requests. Staff member G stated there were many maintenance issues in the building they were not aware of, but they tried their best. Staff member G stated they were responsible for the inside and outside maintenance of the entire building, on top of the assisted living facility nearby. Staff member G stated they had a lot on my (their) plate. Staff member G stated the facility had tried to fill a similar position to help with the work load, but those staff members never seemed to stay long enough. 51111 During an observation of the Rosebud unit's medication room on 11/6/24 at 10:26 a.m., the one sink in the room had a yellow oval shaped pill with the imprint '251' laying on the bottom of it. The sink had the following visible items: - dark and light brown stains in the bottom of sink which looked like hardened substances, - a substance which appeared to be biofilm oozing out of the drain with melted pills layered in it, - a layer of caked yellow substance around the drain, - standing water due to obstruction of the drain by the biofilm, - numerous brown splatters of substance on the bottom of the sink, (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- circular light blue gray spots on the bottom of the sink which looked like mold growths, - residue from brown liquids or substances caked on to the sides and bottom of the sink, - circular brown ring stains which appeared as if cups were kept in the sink and the bottom of the cup left stains from being left for a length of time, - the faucet handles and top of sink had dried and hardened white chalky looking layers of crust, and - a strong odor of wastewater in the room around the sink. During an observation on 11/6/24 at 10:29 a.m., next to the Rosebud medication room sink faucet handles, were two bottles of hand soap. There was a bottle labeled Multi Purpose Cleaner behind the soap bottles. By the edge of the sink were several bottles of pill destroyers. There was one bottle next to the sink with a red funnel labeled Super QuickFill Funnel in place on the open bottle for pills to be poured into. There was no signage around the sink for the sink not to be used. There was no section of the sink blocked off or covered from usage. During an observation on 11/6/24 at 10:31 a.m., on the ceiling above the medication refrigerator was a ceiling tile missing. There were exposed open cords dangling down from a fixture in the center of the ceiling. There was a visible circular grayish colored stain on a ceiling tile next to the open ceiling tile, which looked like a dried water stain. During an interview on 11/6/24 at 3:02 p.m., staff member C stated nursing staff were supposed to clean the medication room regularly. Staff member C stated if there was a large mess made, We would help clean it up. Staff member C stated the sink was not to be used by staff, due to an issue with water coming up the pipe and not going back down. Staff member C stated she has worked at the facility for a year and the sink has had the issue with water not draining. During an interview on 11/7/24 at 8:38 a.m., staff member T stated the Rosebud unit medication room sink had not been working right for a while because the sink water didn't drain down. Staff member T stated she did not use the sink but did not know about the cleaning of it or any work repairs done on the sink. During an interview on 11/7/24 at 8:53 a.m., staff member A stated he would look to see if there was any record of maintenance requests for repair of the Rosebud unit medication room sink. Staff member A stated the maintenance staff member used a Whatsapp messenger for receiving messages about maintenance requests. Staff member A stated they would need to get back in the routine of using hard copy maintenance requests and work orders. During an observation and interview on 11/7/24 at 10:22 a.m., staff member U observed the condition of the sink in the Rosebud unit medication room. Staff member U stated the housekeeping staff cleaned the common area around the nurses station but not inside the medication room. Staff member U stated she had never been asked to go clean in medication rooms. Staff member U stated she could have housekeeping staff clean the medication room with nursing staff present. (continued on next page)

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A request made on 11/7/24 for facility documents of maintenance repairs or maintenance notes on the Rosebud Medication Room sink for January through October 2024, but were not received by the end of the survey.