STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. Building B. Wing	11/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Billings Rehabilitation and Nursing LLC	600 S 27th St Billings, MT 59101

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45448 Based on observation, interview, and record review, the facility failed to provide a safe and secure environment with sufficient supervision to prevent elopement for 1 resident (#32) of 3 sampled residents, which resulted in a hospitalization for the resident. Findings Include: Review of a Facility Reported Incident, dated 10/7/21, showed resident #32 eloped from the facility on 10/7/21 at 11:40 a.m., and was found on 10/8/21 at 9:28 a.m., at his son in-law's home, asleep on the couch. Resident #32 was taken to the hospital by police and admitted for dehydration and altered mental status. The Facility Reported Incident included documentation showed the resident was missing for 18 hours, and did not show resident #32 had altered mental status or dehydration at time of the elopement. Resident #32 returned to the facility on [DATE]. Review of resident #32's Elopement Risk Assessment, dated 9/29/21, showed the resident had eloped from a the previous facility, less than 30 days prior to admission to current facility. The document also showed a care plan intervention of needs monitored by staff, wander guard ordered and placed. Review of an un-titled and un-dated facility document showed, Patio door was locked. [Staff member] was told she could let the residents out on patio if she stayed with them. The fence was down at the time. [Staff member] took residents out on the patio; however, did not lock the door again after she brought them in. The document showed after reviewing the cameras, resident #32 stood in the activities room by a pillar and walked out to the patio when he saw no staff was watching. He sat on a patio chair for a while then walked off the patio as the fence/gate was down. Review of a un-titled and un-dated facility document showed, Floor staff had witnessed [Resident #32] standing in the Activity room near a pillar . Staff were not checking residents as frequently as needed . Review of resident #32's [Entity Name] report, dated October 2021, showed an order for, Wander guard in place for safety-please check function and placement q shift every shift for elopement risk, start date 9/30/21 and D/C date 10/12/21. Documentation for shift checks on 10/1/21, 10/3/21 and 10/6/21 were not present on the [Entity Name] report. A second order showed Wander guard in place for safety- please check function and placement q shift. Wander guard expiration date 4/2024. Every shift for elopement risk, start date 10/12/21 and D/C date 11/22/21. Documentation for shift checks on 10/14/21, 10/18/21, and 10/20/21 were not present on the [Entity Name] report. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. Building B. Wing	11/24/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/23/21 at 12:42 p.m., staff member E stated there were cameras at the doors, and a main screen was located at the nurse's station. The cameras could also be accessed by cell phone or other facility computers. The screens at the nurse's station are not monitored. During an interview on 11/23/21 at 12:54 p.m., staff member F stated the fence was down on the non-smoking area, and there was a delay with the fencing company in putting it back up. Staff member F stated the door to the smoking patio contained an alarm, and a lock with a code for entry, and exit. Staff member F said the door on the non-smoking patio door did not have an alarm and was locked with a key. Staff member F said resident #32 was discovered missing when the nurse went into his room for the afternoon med pass at 2:10 p.m., and found his lunch tray had not been touched. A code pink was then called and a search by staff was initiated. Staff member F stated resident #32 was initially admitted for the secured unit. The facility did not have any openings at that time in the secured unit, and the facility placed resident #32 in a non-secured room. Staff member F stated, The Administrator wanted him taken anyway (accepted for admission), social services wanted a wander guard placed and resident watched closely. Review of document titled, Elopement of [Resident #32] dated 10/8/21, showed the facility did not discover resident #32 was missing for 2.5 hours. During an observation on 11/23/21 at 1:35 p.m., the smoking door was propped open with a towel, the door alarm was sounding, but couldn't be heard over the noise of the heater running. During an observation on 11/23/21 at 1:36 p.m., the alarm system at the nurse's station was noted to make the same alarm sound for both the door alarm, and the resident call lights. No staff members were present at the nurse's station to hear the door alarm had been activated. Review of facility policy titled Elopement Risk, with a revision date of March 2019 showed .6. Following are possible individualized interventions which may include, but are not limited to: a. Account for residents at risk for elopement every 30 minutes .