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	11/21/2022

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 41652 Based on observation, interview, and record review, the facility failed to ensure a resident's call light was within reach and accessible for 1 (#45) of 1 sampled resident, and the resident had to use the restroom but could not call for assistance. Findings include: During an observation and interview on 11/19/22 at 1:50 p.m., resident #45 was sitting in his wheelchair and began pointing to his groin area. When asked if he needed help, resident #45 nodded his head up and down. Resident #45's call light was found draped in the top drawer of his bedside stand with the drawer almost completely closed. The path to the call light was blocked by the resident's over-bed table and his walker. When the resident was instructed to push his call light for assistance, he was not able to maneuver his wheelchair around the walker or over-bed table and continued to point to his groin, indicating he needed assistance. When asked if he needed assistance reaching his call light, the resident nodded his head up and down. Review of resident #45's Quarterly MDS, with an ARD of 8/14/22, showed the resident required supervision of one staff member for transfers and toileting, and limited assistance of one staff member for dressing. The Bladder and Bowel section showed resident #45 was occasionally incontinent of both bowel and bladder.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 40068 Based on an observation, interview, and record review, the facility failed to promote self-determination regarding a resident's choice in sleeping arrangements for 1 (#66) of 1 sampled resident. Findings include: During an observation and interview on 11/20/22 at 4:00 p.m., resident #66 had a scoop mattress. His bed had multiple items stacked on top of it. Resident #66 stated his back hurt because had to sleep in his recliner chair at night. He stated he could not sleep in the bed because it was uncomfortable. He stated if he had a normal mattress he would want to sleep in his bed. During an interview on 11/20/22 at 4:13 p.m., staff member E stated resident #66 was not a fall risk, and therefore did not have any fall interventions. Staff member E stated she was unsure why resident #66 had a scoop mattress. During an interview on 11/21/22 at 3:30 p.m., staff member B stated the scoop mattress on resident #66's bed does not impede him from getting out of bed, however they were looking into getting him a different mattress. Staff member B did not know if he was assessed for the scoop mattress. Staff member B stated she did not know that resident #66 was not sleeping in his bed due to the mattress being uncomfortable. Review of resident #66's medical record showed an assessment for the scoop mattress was not completed.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46400 Based on observation, interview, and record review, the facility neglected to ensure sufficient staff were available and working on the secure unit to supervise, protect, prevent, or intervene in resident to resident physical, sexual, and psychosocial abuse involving 9 (#s 14, 16, 17, 32, 35, 48, 50, 53, and 58) of 15 sampled residents, as evidenced by ongoing resident to resident abuse incidents, and these events caused physical injury, residents had fear of others, or were targeted by other residents, and some continued to be at risk for ongoing abuse; and, 4 (#s 30, 31, 34, and 55) residents were identified to need more than supervisory assistance of the facility staff when it was not provided sufficiently by the facility. The deficient practices were a system failure specifically identified for the secure unit, and the lack of staff, resident oversight, thorough and effective investigations of the abuse incidents, identification and evaluation of root causes for ongoing incidents, and the lack of the identification and implementation of individualized resident interventions based on incident findings and root cause analysis were all contributing factors to the failure(s). These failures increased the risk for abuse for all residents residing on the secure unit. IMMEDIATE JEOPARDY On 11/21/22 at 1:54 p.m., the facility management team was notified that an Immediate Jeopardy existed in the area of F600. The Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of a K. Findings include: 1. During an observation on 11/19/22 at 1:28 p.m., resident #53 was wandering in and out of various resident rooms and closing the doors behind him. There were no staff in the vicinity to redirect his behavior. Resident #53's room was at the end of the hall, furthest from the nursing station, and adjacent to resident #32's room. Review of a facility reported incident, dated 11/23/21, showed, [Resident #53] had his hand in [Resident #32's] shirt. Appeared that he (#53) was attempting to put his other hand down her (#32's) pants when they were separated. Review of facility investigation files on 11/20/22, showed a copy of the statement made by the staff member who had been working the date of the incident (11/23/21), and a copy of the reportable information submitted to the State Survey Agency. There was no information on how the facility intended to keep residents safe during the investigation. Review of resident #32's care plan, most recent revision dated 11/7/22, did not address her vulnerability for ongoing sexual abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of resident #32's nursing progress notes, dated 12/10/21, showed, [Resident #53] found laying in [Resident #32's] room under her covers while [Resident #32] layed in only her underwear with shirt pulled up and breasts exposed. [Resident #53's] hand was on one of [Resident #32's] breasts .Later in the shift [Resident #53] was found again sleeping in [resident #32's] bed with no pants on. [sic] Review of facility investigation files on 11/20/22, showed a copy of the statement made by the staff member working the date of the incident (12/10/21) and a copy of the reportable information submitted to the State Survey Agency. There was no information on how the facility intended to keep residents safe during the investigation. Review of resident #32's nursing progress notes, dated 12/10/21, showed no nursing assessment of the resident for physical or psychosocial harm. Review of resident #53's nursing progress notes, dated 12/10/21, showed he was removed from resident #16's bed and educated not to lay in her bed before he was found there again later that same night. Review of resident #53's care plan, dated 9/29/22, revealed a lack of interventions or monitoring to prevent him from wandering into other residents rooms. Review of resident #32's EHR, accessed on 11/20/22, failed to show a completed Sexual Consent Capacity Assessment for resident #32. A request was made for the Sexual Consent Capacity Assessment on 11/20/22 at 11:00 a.m. The assessment requested was completed on 11/20/22 at 11:10 a.m. and was not provided prior to the end of the survey. During an interview on 11/20/22 at 9:39 a.m., NF1 stated, There is only one person back there (on the secure unit) working on nights with fourteen people (residents) walking around. During an interview on 11/21/22 at 9:29 a.m., staff member G stated, I'm not gonna lie there is only one CNA back here (on the secure unit) at night. She stated it (resident care) was too much for one person. Staff member G stated, You're basically running the unit. They put someone with you now, but the other person (PCA-care assistant) is not hands on and can only hand out waters. Review of the facility document, Care Assistant SNF Temporary Position, dated 7/1/18, showed the duties and responsibilities included, .to provide support and assistance to the nurses and certified nursing assistant with non-direct resident care needs. 2. Review of a facility reported incident, dated 5/28/22, showed, [Resident #53] wandered into [resident #58's] room. [Resident #58] took a gait belt and struck [resident #53] across face with the buckle end. Review of two witness statements regarding an incident between resident #58 and resident #53 on 5/28/22 showed resident #58 had attacked resident #53 with a gait belt and hit him in the face repeatedly when resident #53 had walked into her room and got into her roommate's bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility reported incident submitted findings, dated 5/31/22, showed, A mesh/Velcro belt that can be attached to the sides of the door frame with the big stop sign in the middle has been ordered to deter residents from going into her room. During an observation 11/19/22 at 1:28 p.m., there was no such sign to deter resident #53 or anyone else from wandering into resident #58's room. During an interview on 11/21/22 at 9:29 a.m., staff member G stated resident #58 got along with the other men on the unit, it was just resident #53 that she targeted. Staff member G stated she was getting off shift and throwing trash away (on 5/28/22) when the incident with the gait belt occurred. Staff member G was able to run in and help the single night aide by taking the gait belt away. Staff member G stated resident #53's face was bleeding, and the scar was still visible. During an interview on 11/21/22 at 10:32 a.m., staff member H stated the licensed nurse from one of the outside halls in the facility was responsible for assessments and behavior monitoring (associated with prn medications) for residents on the secure unit. Review of a facility reported incident, dated 8/12/22, showed a nurse was called to the unit after resident #58 was the aggressor striking resident #53. Findings were a minor injury to resident #58's hand and none to resident #53. Review of facility investigation files and the care plans of residents #53 and #58 show a lack of specific interventions to protect the residents from further altercations. Review of a facility reported incident, dated 8/19/22, showed resident #53 was again attacked by resident #58. This incident resulted in resident #53 receiving lacerations to his right cheek and along his neck. Review of a facility reported incident, dated 10/3/22, showed resident #53 received a bite mark from resident #58 during an altercation. Both residents were scheduled for a tele psych appointment. Review of resident #58's care plan, dated 10/31/22, showed a lack of interventions to address the incidents between these two residents in a 5-month span, from 5/28/22 to 10/3/22. Review of resident #53's care plan, date initiated 11/2/21, showed, Verbally aggressive, physically aggressive. Four interventions were listed: - Requesting a psych to psych encounter to [NAME] clinic and med increase (11/17/22), - Resident has had 2 med adjustments made by psych provider (2/3/22), - SW has made a referral for [Facility Name] (2/3/22), - Staff will monitor and intervene when my behaviors occur (11/2/21) The interventions include: redirect me and offer private conversation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of resident #53's care plan, dated 9/29/22, showed a lack of new interventions or non-pharmacological attempts to prevent further incidents of abuse. Resident #53's care plan failed to address he was vulnerable to being a victim of abuse in addition to an aggressor. During an interview on 11/21/22 at 9:29 a.m., staff member G stated resident #s 16, 35, 53, and 58 did not get along. Resident #s 16 and 58 targeted resident #53 calling him a child molester. Staff member G stated she tried to remove resident #53 from the situation, but resident #s 16 and 58 would walk past resident #53 and say things to rile him up. Staff member G stated she had seen resident #53 crying when he was singled out by other residents. During an observation on 11/19/22 at 1:32 p.m., resident #16 was walking the hallways with her walker visually policing resident #53's movements. She went to the dining room and was whispering to other residents to notify them that resident #53 was now up and walking in the hallway. Resident #16 appeared tense. 3. Review of a facility reported incident, dated 1/23/22, showed, [Resident #53] was inappropriately touching a female resident. The staff separated both residents .[Resident #53] then entered several female's rooms, pulling their covers off and attempting to touch them inappropriately .[Resident #53] was removed by 911 police department and taken to E.R. [sic] Resident #s 16 and 35 were listed as victims of this incident. The facility investigation file, reviewed 11/20/22, contained a witness statement from the staff member working that day and a copy of the reportable information submitted to the State Survey Agency. No documentation of steps taken to protect residents during the investigation was included. Review of resident #35's care plan, revision date 9/8/21, showed, I am a vulnerable adult and at risk for dangerous situations due to my cognition . Interventions: Staff to redirect away from other residents that are exhibiting behaviors/agitation for her safety. The resident's care plan failed to show any updates or new interventions after the 1/23/22 incident. Review of resident #35's nursing progress notes, dated 1/23/22, showed a lack of resident physical or psychosocial assessment immediately after, or in the days following, the incident. Review of resident #16's nursing progress notes, dated 1/23/22, showed a lack of resident physical or psychosocial assessment immediately after, or in the days following, the incident. During an observation on 11/21/22 at 11:15 a.m., the staffing schedule for the night showed one CNA scheduled on the secure unit oversight of all the residents. 4. Review of resident #48's nursing progress notes, dated 11/13/22, showed, Upon entering room, pt was getting hit on the back of his head by another resident [Resident #53]. [sic] Review of a facility reported incident, dated 11/13/22, showed when the nurse opened the door to resident #48's room, resident #48 was on the floor with resident #53 on top of him. The residents were striking each other. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 11/19/22, resident #48 was sitting in his wheeled walker just inside the doorway of his room, directly across the hallway from resident #53's room. Resident #48 was closely watching resident #53 who was walking in the common hallway. Resident #48 pointed at resident #53 and stated, He hurt me bad. 47003 5. Record review of 14 facility reported resident to resident and staff to resident incidents from 11/23/21 to 11/13/22 for the secure unit which showed four incidents occurred between 2:50 p.m. and 6:30 p.m., and nine incidents occurred between 6:30 p.m. and 9:15 p.m. Review of the facility provided schedule showed that night shift worked from 6:00 p.m. to 6:30 a.m. Review of facility investigation documents into an incident with resident #50, and a staff member, on 8/1/22 showed, resident #50 ripped a closet door from its hinges and became physically aggressive towards staff member N who was aiding another resident with changing their clothes. This resulted in a physical and verbal altercation between resident #50 and staff member N. Staff Member N had to lock herself and the resident she was aiding in a bathroom until resident #50 stopped banging on the door to the bathroom. The investigation documents provided showed only staff member N had a direct interaction with resident #50 and gave a statement regarding the incident. The statement from staff member L relayed the events after she relieved staff member N from the secure unit. There were no other staff member statements regarding having directly witnessed the actual incident. 6. During an observation on 11/19/22 at 3:22 p.m., resident #30 was in the TV room and picked up an unplugged electronic device below the TV. Resident #30 carried the electronic device around the room, with the cord dangling for several minutes. There were two other residents in the room at that time. Resident #14 became agitated and told resident #30 to put the device down. There were two staff members present in the secure unit assisting other residents, neither staff member entered the TV room and redirected resident #30 from picking up or replacing the device on the table, nor noticed resident #14's increased agitation. During an interview on 11/20/22 at 2:14 p.m., staff member G stated the facility expectation was the CNA assigned to work on the secure unit would watch all residents all the time. Staff member G stated it was not possible when several of the residents required direct CNA or nursing assistance with toileting or dressing, as well as the frequent redirection required for most of them. Review of the current care plans for 4 residents residing on the secure unit, and included in the immediate jeopardy situation, showed: - Resident #14 care plan, dated 11/10/22, required 1:1 staff supervision for aggressive/anxious behavior, monitor for rummaging through other's belongings, and assistance with ADLs, - Resident #17 care plan, dated 10/7/22, required extensive assistance of one staff for dressing, bathing, grooming, and toileting, - Resident #50 care plan, dated 10/11/22, required supervision to limited assistance with dressing, bathing, grooming, and toileting, and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Resident #58 care plan, dated 10/31/22, required assistance of one staff for transport to group activities and location checks for wandering/elopement and assistance of two staff for relocation to other areas of unit for aggressive behavior, Review of the current care plans and MDS information of four sampled residents on the secure care unit, but not part of the immediate jeopardy, were included to show additional staffing concerns due to increased care needs showed: - Resident #30 care plan, dated 8/27/22, needed monitoring for seizure activity and required limited to extensive assistance with bathing and dressing, and assistance with oral care, - Resident #31 care plan, dated 8/24/22, required supervision to extensive assistance with toileting and ambulation, extensive assistance with transfers, and assistance with oral care, - Resident #34 care plan, dated 10/20/22, required monitoring for sexually inappropriate behavior, supervision with transfers, bed mobility and ambulation, supervision with toileting, and assistance with oral care, and - Resident #55 Admission MDS, with an ARD of 8/28/22, required a one person physical assistance with his activities of daily living, and was frequently incontinent of bowel and bladder. During an interview on 11/21/22 at 9:26 a.m., staff member G stated she usually worked on the secure unit, and in the time she had been employed at the facility, the night shift frequently had only one CNA working on the secured unit without a PCA or second CNA. Regarding an incident with resident #50 which happened on the night shift on 8/1/22, staff member G stated there had only been one CNA on the shift with no other CNA or PCA. Staff member G stated when working alone, during an emergency situation there was no way for a CNA to request help from other staff members outside the secure unit other than using the telephone or yelling very loudly so other staff could hear. The main nurse's station was approximately 30 feet from the closed double doors leading to the secure unit. During interviews on 11/21/22 at 8:20 a.m. and 10:03 a.m., staff member B stated two staff members were scheduled for the secure unit at all times, either two CNAs or a CNA and a PCA. The PCA was only allowed to do activities and non-direct patient care. If a staff member assigned to the secure unit called in ill, the facility used a call list to find another staff member to come in to fill the shift. If no one was found, it was up to the remaining staff in the facility to ensure at least two staff members were in the secure unit at all times. Staff member B was unsure why there was only a statement from one CNA regarding direct contact with resident #50 on the night of the incident on 8/1/22. Staff member B stated beyond going through the call list to find another staff member to fill in, there was no actual policy or procedure for ensuring the secure care area had two employees working every shift. Staff member B stated the cause for the majority of the incidents occurring later in the day was most likely due to sundowning, and they had been trying to get more PCAs trained to do activities as the facility was trying to move away from hiring contract staff, but they had not specifically looked at adding additional resident supervision during that time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/21/22 at 9:20 a.m., staff member M stated she was unsure where to find care plan interventions for resident behaviors or how to redirect specific residents on the secure unit if the CNA was with another resident and she had to intervene in an altercation between residents. Staff member M stated she would have to leave her area or room to find the CNA to ask her what to do. 7. During an interview on 11/19/22 at 3:43 p.m., NF3 stated resident #58 had experienced a lot of traumatic events in her past, and she specifically had difficulties with men. NF3 stated that the facility had not really done anything to make the situation (between resident #58 and resident #53) safer, and it will probably happen again. During an interview on 11/20/22 at 2:14 p.m., staff member G stated resident #53 was not usually the aggressor in situations with resident #58, and resident #53 seemed to trigger resident #58's violent behavior. During an interview on 11/21/22 at 1:29 p.m., NF4 stated during the initial admission care conference for resident #58, the history of trauma and abuse was a main topic of the conversation. Review of facility reported incidents for resident #58 from 5/19/22 to 10/7/22 showed she had four physical resident to resident altercations and all of them involved resident #53. Review of a provider psychology telehealth encounter for resident #58, dated 8/24/22, showed, .[Resident #58] attacked another resident. She sharpened her fingernails so she could scratch him. She is afraid of one of the residents, calls him a rapist and this is the resident she attacked Social history: hx of sexual abuse and hx physical abuse .resident is aggressive, combative, and has assaulted another resident. [sic] During an interview on 11/21/22 at 8:20 a.m., staff member B stated many of resident #58's behaviors toward resident #53 were due to her history of PTSD and the facility monitored as closely as they could to keep resident #58 and resident #53 seperated. Review of resident #58's care plan, last reviewed 10/31/22, showed, I will have staff order mesh stop signs to prevent others from entering into my room. There were no interventions related specifically to monitoring resident #58 to direct her away from contact with males, especially resident #53. A mesh stop sign was never observed across the doorway to resident #58's room when resident #53 was observed walking in the hallways. 8. Review of the facility's investigation for the facility reported incident into bruising of unknown origin on resident #50's hip, dated 5/13/22, and bruising of unknown origin on resident #50's bicep, dated 5/19/22, both showed a list of staff with the word no written next to staff member names. No other investigative paperwork was provided for the incidents, aside from the copy of the reported information submitted to the State Survey Agency. The information reported showed the resident frequently likes to throwing herself on the bed and swinging at objects. [sic] Review of resident #50's Admission MDS, with an ARD 3/28/22, Section E, showed the resident exhibited no behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of resident #50's care plan, dated 10/11/22, failed to show any behaviors or interventions as described in the incidents reported on 5/13/22 and 5/19/22. 9. During an observation and interview on 11/19/22 at 1:42 p.m., resident #14 was noted to have bruising around her right eye. The resident stated she got the black eye when the tall man punched her. She indicated the tall man was resident #53. Resident #14 was unsure why resident #53 had punched her. During an observation on 11/19/22 at 1:46 p.m., resident #14 became nervous and scared when she saw an unfamiliar female standing in the hallway outside of resident #53's room. Resident #14 called out to the unfamiliar female in an attempt to direct her away from resident #53's room. During an observation on 11/20/22 at 2:14 p.m., resident #14 walked into her room, then walked down the hall into and out of another resident's room, while staff were busy assisting other residents. Review of resident #14's care plan, dated 11/10/22, showed, resident #14 required 1:1 staff supervision for aggressive/anxious behavior, monitor for rummaging through other's belongings, and assistance with ADLs, I often go into other resident's rooms . The interventions listed were both for staff to redirect, and were last revised on 8/13/21. 32997 During an interview on 11/21/22 at 3:20 p.m., staff member I entered the conference room and said she did not know how the facility would remove the immediate jeopardy. Staff member I said the facility could not get any more staff for the secure care unit. Staff member I stated This close to the holiday we can't get any contract staff either. Staff member I stated We are going to have to call the families and tell them to come get their residents. If they won't take their residents home, we are going to have to transfer them to the hospital and refuse to take them back. During an interview on 11/21/22 at 5:36 p.m., staff member N said he was going to write discharge orders and send two residents to the hospital. Staff member N stated It sounds like the facility can't get any additional staff until December 2nd, and it appears the only way to address this situation is to send these residents to the hospital. One resident can go to [Hospital name] and the other resident can go to [hospital name]. Review of a facility document titled, Abuse Prevention Plan, review date November 2022, showed: Neglect - .The failure of a caregiver to supply a resident with the care or services, including but not limited to food, clothing, shelter, health care or supervision which is reasonable and necessary to obtain or maintain the resident's physical and mental health or safety, considering the physical or mental dysfunction of the resident which is not the result of an accident or therapeutic conduct. and - .The absence or likelihood of absence of care or services necessary to maintain the physical and mental health of the resident and which a reasonable person would deem essential to obtain or maintain the Resident's health, safety and comfort, considering the physical and mental capacity of the resident. and (continued on next page)

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	275120	A. Building B. Wing	11/21/2022

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- .Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances . lack of sufficient staffing to be able to provide the services.

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F 0610 Level of Harm - Actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 46400 Based on observation, interview, and record review, the facility failed to prevent and protect residents from ongoing sexual, physical, or emotional abuse for 6 residents residing on the secure care unit (#s 8, 16, 32, 35, 53, and 58) of 29 sampled residents. This deficient practice allowed residents to continue to be at risk for further abuse, and resident #53 had multiple injuries, to include stitches, female residents exhibited fear, and were risk for sexually inappropriate touching. Findings include: 1. Review of a facility reported incident, dated 11/23/21, showed, [Resident #53] had his hand in [resident #32's] shirt. Appeared that he (resident #53) was attempting to put his other hand down her (resident #32's) pants when they were separated. Review of the facility investigation file, on 11/20/22, showed a written statement from the staff member working the night of the alleged sexual abuse (11/23/21), involving resident #32 and 53, and a copy of the reported information submitted to the State Survey Agency. There was a lack of root cause analysis or information about how the facility intended to protect resident #32 from further sexual abuse. Review of resident #32's nursing progress notes, dated 12/10/21, showed, [Resident #53] found laying in [resident #32's] room under her covers while [resident #32] layed in only her underwear with shirt pulled up and breasts exposed. [Resident #53's] hand was on one of [resident #32's] breasts . Later in the shift [resident #53] was found again sleeping in [resident #32's] bed with no pants on. [sic] Review of the facility investigation file, on 11/20/22, revealed a written statement from the staff member working the night of the second alleged sexual abuse (12/10/21), and a copy of the reported information submitted to the State Survey Agency. There was a lack of root cause analysis or information about how the facility intended to protect resident #32 from further sexual abuse. During an interview on 11/21/22 at 9:29 a.m., staff member G stated she could not speak to a specific plan or process to keep specific residents separated. 2. Review of the facility reported incidents, dated 5/28/22 to 10/3/22, showed resident #53 had been physically abused by resident #58 on four different occasions. Consequences of these altercations included being hit across the face with a gait belt buckle, scratched along his face and neck with fingernails, and being bitten hard enough to leave a bite mark. Review of the facility investigation files, viewed on 11/20/22, for the abuse events between resident #53 and 58, showed a lack of information on how the facility intended to prevent ongoing abuse while determining the root cause of the separate incidents. Review of the facility reported incident findings, submitted to the State Survey Agency, dated 5/31/22, showed, A mesh/Velcro belt that can be attached to the sides of the door frame with the big stop sign in the middle has been ordered to deter residents from going into her [resident #58] room. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Some	During an observation on 11/19/22 at 1:28 p.m., there was no mesh/velcro belt sign to deter resident #53 or any other residents from wandering into resident #58's room. 3. Review of a facility reported incident, dated 1/23/22, showed, [Resident #53] was inappropriately touching a female resident. The staff separated both residents .He (resident #53) then entered several female's rooms, pulling their covers off and attempting to touch them inappropriately .[Resident #53] was removed by 911 police department and taken to E.R. Resident #16 and #35 were listed as victims of this incident. The facility investigation file, related to the abuse events on 1/23/22, reviewed on 11/20/22, contained a witness statement from the staff member working the day of the alleged sexual abuse (1/23/22), and a copy of the reportable information submitted to the State Survey Agency. No documentation of steps taken to protect resident #16 or #35 from further abuse by #53, while the investigation was ongoing were included. 41652 4. Review of the investigation of an incident reported to the State Survey Agency, which occurred on 2/12/22, involved an allegation of verbal abuse by staff member C towards resident #8. The investigative documents showed staff member C was prohibited from caring for resident #8 but was allowed to care for other residents without continuous supervision. During an interview on 11/21/22 at 1:35 p.m., staff member B stated she performed the investigation of the incident between resident #8 and staff member C. Staff member B stated resident #8 was protected from further abuse during the investigation. However, staff member B stated she did not protect other residents during the investigation as staff member C was allowed to continue working with other residents without direct supervision.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 47003 Based on observation and interview, the facility failed to sufficiently show the timely assessments, emergent need, or it's inablity to care for residents before initiating and completing an emergent discharge, for 3 (#s 50, 53, and 58) of 3 sampled residents. During an interview on 11/21/22 at 3:56 p.m., NF3 stated distressingly, The facility administration just called and told me they are discharging [Resident #58] today because of what I told you (to the surveyor during an interview on 11/19/22). What am I going to do? 32997 During an interview on 11/21/22 at 5:36 p.m., staff member N said he was going to write discharge orders and send two residents to the hospital. Staff member N stated, It sounds like the facility can't get any additional staff until December 2nd, and it appears the only way to address this situation is to send these residents to the hospital. One resident can go to [hospital name], and the other resident can go to [hospital name]. The concern for care was related to staff availablity. During observations on 11/21/22 from 5:45 p.m. to 6:50 p.m., ambulance transports were observed at the front doors of the facility. Ambulance staff brought gurneys into the building. A short time later transport gurneys were observed leaving the building with resident #50, #53, and #58. 46400

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41652 Based on interview and record review, the facility failed to provide the resident with a written notice of the reason for a transfer, or show documentation for this in the resident EHR's, for 2 (#s 33 and 36) of 2 sampled residents. Findings include: 1. After multiple attempts, between 11/19/22 at 1:30 p.m. and 11/21/22 at 4:00 p.m., to interview resident #33, the resident was either sleeping or unavailable to interview. Review of resident #33's nursing progress note, dated 5/9/22, showed the resident was having difficulty breathing and was sent to the hospital for evaluation. Review of resident #33's eINTERACT SBAR note, dated 7/25/22, showed the resident had abnormal vital signs with an elevated blood pressure of 187/84, an elevated pulse of 116 beats per minute, and a low oxygen saturation of 79 percent. The note also showed the resident was having respiratory distress and was sent to the hospital for further testing. Review of resident #33's nursing progress note, dated 9/15/22, showed the resident had an oxygen saturation, . running 70's even with incre4asing [sic] oxygen to 6L via NC. The note showed the resident was sent to the hospital for care. Review of resident #33's nursing progress note, dated 9/25/22, showed the resident had just returned on 9/22/22 from a week long hospital stay, had an oxygen saturation in the 80's with oxygen at 3 liters per minute, and was short of breath. Review of resident #33's EHR, accessed on 11/21/22, failed to show documentation of the written transfer notices for the transfers which occurred on 5/9/22, 7/25/22, 9/15/22, and 9/25/22. During an interview on 11/21/22 at 7:45 p.m., staff member I stated the facility had one of the transfer notices for resident #33 and would provide it as soon as possible. A request for the written transfer notices for resident #33 was made on 11/21/22 at 8:36 a.m. None were received prior to the end of the survey. 2. During an interview on 11/19/22 at 4:45 p.m., resident #36 stated he remembered recently being hospitalized for a UTI. Resident #36 stated he was quite ill and did not remember receiving any paperwork regarding the reason for the transfer. Review of resident #36's EHR, accessed on 11/21/22, failed to show documentation of the provision of a written notice of the reason for the resident's transfer which occurred on 8/14/22. A request for the written transfer notice for resident #36 was made on 11/21/22 at 3:50 p.m. None was received prior to the end of the survey. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Notice of Transfer or Discharge to Ombudsman Policy, last revised March 2019, showed the notice may be provided as soon as practicable. The policy failed to show a procedure for how the notice was to be provided when an emergency transfer occurred.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 41652 Based on interview and record review, the facility failed to provide the resident with written information regarding the bed-hold policy, including the duration of the state bed-hold policy and any payment required, for 2 (#s 33 and 36) of 2 sampled residents. Findings include: 1. Review of resident #33's nursing progress note, dated 5/9/22, showed the resident was transferred to the hospital for evaluation of his difficulty breathing. Review of resident #33's eINTERACT SBAR note, dated 7/25/22, showed the resident was transferred to the hospital for evaluation of abnormal vital signs and respiratory distress. Review of resident #33's nursing progress note, dated 9/15/22, showed the resident was transferred to the hospital for a low oxygen saturation despite an increase in oxygen. Review of resident #33's nursing progress note, dated 9/25/22, showed the resident had just returned on 9/22/22 from the hospital and was transferred back on 9/25/22 because of shortness of breath and low oxygen saturations. Review of resident #33's EHR, accessed on 11/21/22, failed to show documentation of the provision of bed-hold information for the transfers which occurred on 5/9/22, 7/25/22, 9/15/22, and 9/25/22. During an interview on 11/21/22 at 7:45 p.m., staff member I stated the facility had the necessary transfer and bed hold documents for one of the transfers for resident #33 and would provide it as soon as possible. A request for the written bed-hold information for resident #33 was made on 11/21/22 at 8:36 a.m. Nothing further was received prior to the end of the survey. 2. During an interview on 11/19/22 at 4:45 p.m., resident #36 stated he remembered recently being hospitalized for a UTI. Resident #36 stated he was quite ill and did not remember receiving any paperwork regarding the facility's bed-hold policy. Review of resident #36's EHR, accessed on 11/21/22, failed to show documentation of the provision of the bed-hold information for the transfer which occurred on 8/14/22. Review of the facility's policy titled, Bed Hold Prior to Transfer, last revised November of 2022, showed the facility was supposed to provide written information regarding bed-hold policies prior to transferring the resident to the hospital. The policy showed, 1. The facility will have a process in place to ensure residents and/or their representatives are made aware of the facility's bed-hold and reserve bed payment policy well in advance of being transferred to the hospital . The policy failed to show what the process was or who was responsible for ensuring the process was accomplished correctly.

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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. 47003 Based on interview and record review, the facility failed to accurately develop an individualized care plan and implement interventions related to a resident's history of past trauma and abuse, which was significant, for 1 (#58) of 6 sampled residents. This failure led to a lack of care plan interventions that could potentially have prevented repeated aggression and physical altercations with injuries to a male resident (#53). Findings include: 1. During an interview on 11/19/22 at 3:43 p.m., NF3 stated resident #58 had a significant prior history of trauma and abuse by males, and she did not trust men. During an interview on 11/20/22 at 2:14 p.m., staff member G stated resident #58 appeared to be aggressive towards resident #53 specifically. Staff member G stated she had been told resident #58 had suffered trauma and abuse in the past. Staff member G said resident #53 seemed to trigger aggressive behaviors for resident #58. During an interview on 11/20/22 at 8:20 a.m., staff member B stated resident #58 was repeatedly aggressive towards resident #53, due to her PTSD. During an interview on 11/21/22 at 1:29 p.m., NF4 stated during the admission care conference, resident #58's history of trauma with men was a main topic of conversation. Review of facility reported incidents for 4/25/22 to 10/3/22 showed resident #58 and resident #53 had four physical altercations resulting in minor injuries to resident #53. Review of resident #58's Admission MDS, with an ARD of 4/25/22, Section E, failed to identify resident #58 had any behavior problems. Section V, care area assessment, failed to show behaviors had been triggered or was the be added to resident #58's care plan. Review of resident #58's care plan, dated 10/31/22, showed no behaviors or interventions related to trauma and specifically trauma with males.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47003 Based on observation, interview, and record review, the facility failed to assess the effectiveness of interventions and to revise individual care plans after resident-to-resident altercations for 2 (#s 14 and 58), bruising of unknown origin attributed to self-harm for 1 (#50) of 3 sampled residents which allowed physical injuries to residents to continue on the secure care unit; and failed to have updated goals and interventions for smoking for 1 (#56) of 2 sampled residents; and failed to ensure the resident's care plan was revised to include all sexually inappropriate behaviors, goals, and interventions for 1 (#45) of 1 sampled resident; failed to develop and implement a pneumonia and oxygen use care plan for 1 (#24) of 2 sampled residents; and failed to update care plans for 2 (#s 28 and 60) of 7 sampled residents. Findings include: 1. During an observation and interview on 11/19/22 at 1:42 p.m., resident #14 was noted to have dark bruising around her right eye. She stated that The tall man punched her about a week ago, and she identified the tall man as resident #53. During an observation on 11/19/22 at 1:46 p.m., resident #14 became scared and nervous when she saw an unknown female standing outside the door to resident #53's room. Resident #14 called out and waved to try and direct the female away from resident #53's room. During on observation on 11/19/22 at 3:22 p.m., resident #14 was seated in the TV room when resident #30 entered and proceeded to pick up an unplugged electrical device and wander around the room for several minutes. Resident #14 became agitated and told her to quit playing with the device. There were two staff members working on the unit at that time, neither staff member redirected resident #30 away from the device or was aware of resident #14's agitation. During an observation on 11/20/22 at 2:14 p.m., staff member G walked away to assist another resident with ambulation, resident #14 was observed walking out of her room, and across the hall, and into and out of another resident's room. No staff members saw or redirected resident #14. Review of a facility reported incident, dated 11/13/22, showed resident #14 had a physical altercation resulting in a black eye from resident #53. Review of resident #14's care plan, dated 11/10/22, showed: - I like to go into other resident's rooms and attempt to help or comfort them . Interventions- Staff will redirect [resident 14] away from entering other resident's rooms, and - safety/vulnerability Interventions- .increased supervision .like to be alone 1 to 1 prn .staff will continue to remove her from dangerous situations .staff to continue to redirect resident and remove her from situation . staff of 1 anticipate and meet all of [resident #14's] safety needs .staff of one assist [resident #14] to recognize dangerous situations . There were no new interventions listed for increased protection from resident #53, and staff were not observed effectively redirecting resident #14's behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview on 11/19/22 at 3:43 p.m., NF3 stated resident #58 had been involved in several physical altercations with a male resident (resident #53) on the secure unit. NF3 stated the facility did not appear to have done anything to make the situation safer, and it would likely happen again. During an interview and observation on 11/20/22 at 2:14 p.m., staff member G stated resident #58 appeared to be aggressive toward resident #53 specifically, and they had been involved in several altercations. Review of facility reported incidents from 5/28/22 to 11/13/22 showed resident #58 had four physical altercations resulting in injuries to resident #53. Review of resident #58's care plan, dated 10/31/22, showed a lack of interventions to prevent or minimize interaction with resident #53, despite multiple facility investigated physical altercations resulting in minor injuries for resident #53. The care plan also showed, I will have staff order mesh signs to put on my door to prevent others from entering my room. No mesh sign was observed placed across resident #58's doorway during observations conducted throughout the survey. 3. Review of a facility reported incident, dated 5/13/22, showed resident #50 had sustained bruises of unknown origin on her hip and lower back on 5/13/22. The facility investigation report showed, Resident frequently throws herself back on her bed. Review of a facility reported incident, dated 5/19/22, showed resident #50 had sustained bruises of unknown origin on her left bicep. The facility investigation report showed, Resident has had behaviors of throwing herself on the bed and recliner and swinging at objects. Review of resident #50's care plan, dated 10/11/22, showed a lack of self-harming behaviors or interventions for monitoring for self-harm. 40068 4. During an observation on 11/19/22 at 2:17 p.m., resident #56 came in the front door, from outside. The resident smelled of cigarette smoke when he entered the building. During an observation and interview on 11/20/22 at 7:50 a.m., resident #56 signed himself out of the facility, left his walker by the door, grabbed his cane, and used the electronic keypad to exit out of the building. He stated he was going out to smoke. He walked out the door and across the parking lot to his truck, which was parked in the facility's parking lot. During an observation and interview on 11/20/22 at 3:02 p.m., resident #56 stated he went out to his car, in the facility's parking lot, to smoke whenever he wanted. He stated that he was allowed to smoke in his truck in the parking lot. Resident #56 stated he kept a set of smoking supplies, which included his lighter and cigarettes, in his truck. He stated he had an additional lighter in his pocket, and cigarettes in his bedside nightstand. Resident #56 then opened his drawer and pulled out a pack of cigarettes. A smoking assessment and care plan were requested on 11/20/22 for resident #56. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #56's Smoking or E-cigarette assessment dated , 11/20/22 showed, What time of the day does resident like to smoke? Morning, Afternoon, Evenings, Nights Does the resident smoke cigaretts or use E-cigarette? cigs. Review of resident #56's care plan, dated initiated 11/20/22, showed, Focus- I am a smoker and I have been safely assessed to smoke. Goal- I want to be able to continue to smoke freely. Interventions- staff will allow me to smoke off property as agreed upon. 41652 5. During an interview on 11/21/22 at 9:00 a.m., staff member Q stated resident #45 had a number of behaviors which needed to be managed. Staff member Q stated resident #45 was sexually inappropriate at times, masturbated at the main nursing station, and the bath house, while CNAs were present. Staff member Q stated resident #45 also groped staff members, primarily CNAs, and was not sure if he had ever groped another resident. Staff member Q stated resident #45 had a history of wandering, in his wheelchair, outside female resident rooms waiting to see if he was able to catch them changing clothes. When asked how resident care plans were updated, staff member Q stated the floor nurses were not involved in care conferences, and care plans were updated based on what was documented by the nurses in the progress notes area of the EHR. Note: During observations in the facility from 11/19/22 at 1:30 p.m. and 11/21/22 at 7:00 p.m., no inappropriate sexual behaviors for resident #45 were observed. Review of resident #45's care plan, last reviewed on 8/24/22, showed the focus area of, . inappropriate sexual behaviors related to my diagnosis of TBI. I go down hall A. The care plan failed to identify masturbation and staff groping as part of the inappropriate behaviors. The goal and interventions sections of the care plan were blank. 32997 6. During an observation on 11/19/22 at 5:13 p.m., resident #28 was in bed. A foam block was tucked under the fitted sheet on the side of the bed facing into the room. Review of resident #28's current care plan, dated 9/20/22, failed to show the resident was using foam blocks for positioning or as a restraint. During an observation on 11/21/22 at 9:09 a.m., two triangular shaped black foam blocks, approximately two feet long by one foot high, were on resident #28's bed. During an interview on 11/21/22 at 9:12 a.m., staff member J said the blocks were put on the side of the bed to keep resident #28 from throwing her legs over the side of the bed, and getting out of bed. Review of resident #28's medical record showed a comprehensive Physical Device and/or Restraint Assessment had been completed on 9/3/22. This assessment failed to show the facility had assessed the triangular foam blocks observed in use for resident #28. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/22 at 2:32 p.m., staff member K was not aware foam triangular blocks were being used by resident #28. Staff member K said resident #28 was receiving hospice services, and it was possible the hospice nurse wrote orders for the foam blocks in resident #28's bed. Staff member K said she would find out. Staff member K said the foam blocks should be identified on resident #28's care plan. Review of resident #28's Hospice Interdisciplinary Team Review document, dated 10/20/22, failed to show the resident was using two foam blocks as a positioning aid or a restraint. Review of resident #28's Annual MDS, with an ARD of 9/8/22, Section P, Restraints, failed to show the resident was using any type of physical restraint. Staff member K failed to provide any additional information related to the two black triangular foam blocks that were being used by resident #28. 7. During an observation and interview on 11/19/22 at 5:16 p.m., resident #60 was sitting in his wheelchair, in the doorway, to his room. Resident #60 said he was doing fine, but he was ready to go home. Resident #60 said he came to the facility for some therapy services after he had a fall at home and had broken his hip. Resident #60 said his doctor wanted him to come to the nursing home for some more therapy to get stronger before he went home. Resident #60 went to the dining room in his wheelchair using his feet to move himself down the hallway. Review of resident #60's Restorative Referral Form, dated 8/4/22, showed the resident was to receive restorative nursing services five times a week to include walking/treadmill as tolerated with stand by assistance, and active range of motion for upper and lower body, using the weight machine. Review of resident #60's care plan, dated 9/29/22, had not been updated to include his restorative nursing program. Review of a facility document titled, Care Planning, revised March 2019, showed, . 11. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. 8. During an observation and interview on 11/19/22 at 2:22 p.m., resident #24 was lying in bed with oxygen, per nasal cannula, in place. When asked why he was on oxygen, resident #24 stated he had been on oxygen since the spring because of pneumonia. Review of resident #24's Quarterly MDS, with an ARD of 6/24/22, showed the addition of a diagnosis of pneumonia, and the use of oxygen. Review of resident #24's Discharge Summary (from acute care hospital stay), dated 10/4/22, showed the resident was treated for pneumonia during the hospitalization . Review of resident #24's hospital Discharge Instructions, dated 10/4/22, showed the resident's SNF Admission Orders included, Oxygen Therapy 2-3 liters per minute per Nasal Cannula. [sic] Review of resident #24's care plan, last revision date 10/10/22, failed to show any problems, goals, or interventions related to pneumonia or oxygen usage.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40068 Based on observation, interview, and record review, the facility failed to monitor residents while smoking, and store smoking supplies in a secure location, for two, #s (27 and 56) out of 2 sampled residents; failed to ensure the residents' environment on the secure unit for the provision of adequate supervision and freedom from hazards, for 1 (#53) of 14 residents sampled, and #53 had an two injuries, one from an an alternate resident (#58), and the other from an injury when unattended. Findings include: 1. During an observation on 11/19/22 at 2:17 p.m., resident #56 came in the front door, from outside. The resident smelled of cigarette smoke once he entered the building. During an observation and interview on 11/20/22 at 7:50 a.m., resident #56 signed himself out of the facility, left his walker by the door, grabbed his cane, and pushed the code on the alarm by the door, and left the building. He stated he was going out to smoke, and he had his ice cleats on. He walked out the door and across the parking lot to his truck, which was parked in the facility's parking lot. During an observation and interview on 11/20/22 at 3:02 p.m., resident #56 stated he goes out to his car in the facility's parking lot to smoke whenever he wants. He stated he is allowed to smoke in his truck in the parking lot. Resident #56 stated he keeps a set of smoking supplies which included his lighter and cigarettes in his truck. He stated he had an additional lighter in his pocket, and cigarettes in his bedside nightstand. Resident #56 then opened his drawer, in his room, and pulled out a pack of cigarettes. During an interview on 11/20/22 at 3:04 p.m., staff member P stated residents who smoke keep their smoking supplies in a box at the nurses station. Staff member P stated there was designated smoking times for the residents, they smoke in the designated area outside the building, on the patio, with a staff member present. Staff member P stated both resident #27 and #56 do not smoke at the designated smoking times, or in the designated area for smoking. Staff member P stated they go out as they please to smoke, and do not have a staff member with them. She stated they (the facility) do not keep their smoking supplies, including their lighters, in the smoking supply box kept at the nurse's station. Staff member P stated they tried to take resident #27's smoking supplies away from her, but the resident just buys more from the store. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/22 at 3:30 p.m., staff member B stated, residents who were admitted prior to 8/1/18 were grand-fathered in (for smoking policy) and have the ability to smoke. Otherwise, there was no smoking allowed for any of the residents admitted after 8/1/18. She stated we have turned away a few admissions because they were smokers. Staff member B stated, all the smoking supplies for each resident that smokes are kept in a box at the nurses station. Staff member B stated there are designated smoking times, and a staff member will bring the smoking supplies out to the designated smoking patio and give the supplies to the residents. There is a staff member outside with the residents when they smoke. The residents who smoke are all assessed as independent smokers, which means they had the ability to manage handling a cigarette when it was given to them. A staff member should always be with the residents when they smoke, and the only designated area to smoke, is the patio. Staff member B stated the facility cannot take resident #27's cigarette supplies away to put them at the nurse's station because she will just get more. Staff member B stated she (#27) is non-compliant with the facility's smoking policy, and she goes out to smoke as she pleases. Staff member B stated resident #27 was given a different smoking agreement then the rest of the residents so she could smoke as she pleased. Staff member B stated the facility gave resident #27 multiple 30-day discharge notices, due to her continued non-compliance with smoking, but the resident refuses to leave the facility. Staff member B stated she was aware that resident #56 checks himself out of the building to go to his truck. Staff member B stated the facility was not expecting resident #56 to live very long, after they admitted him, but he had recovered. The facility learned later he was a smoker. Staff member B stated they are currently trying to find him a more suitable placement. Staff member B stated resident #56 was admitted after 8/1/18. Review of resident #56's Smoking or E-cigarette assessment dated , 11/20/22 showed, What time of the day does resident like to smoke? Morning, Afternoon, Evenings, Nights; Does the resident smoke cigarettes or use E-cigarette? cigs. Review of resident #27's Smoking or E-cigarette assessment dated , 3/7/22 showed, .8. Does resident need facility to store lighter and cigarettes or E-cigarette? 1. Yes .10. Comments: [Resident] goes out of the facility alone to smoke as often as she desires. Staff reports [Resident] has several burn areas on front of her coat from falling ashes. [Resident] questioned about the burns, she reports the burns occurred while a gust of wind came up and blew ashes off her cigarette. She also states that other than that time, she has never burnt her clothing while smoking. Facility policy titled, Smoking Policy- Grandfathered Residents with a revision date of 11/22 showed, .Failure to comply with the smoking policy may result in restricting or forfeiting smoking or visiting privileges. If the danger or lack of compliance is serious enough, it may warrant discharge in accordance with state and federal law. The community will be a non-smoking community for new admissions beginning 8/1/18 for MT and 9/1/18 for SD, NE, and IA. Review of facility document titled, New Smoking Guidelines signed by resident #27 on 8/7/18 showed, Smoking supervision with designated smoking times. 2 cigarette limit for each designated smoking time slot. No smoking materials or lighters kept on your person including lighters. No smoking on company property or on sidewalks. We are no longer a smoking facility. All current smokers will be grandfathered in under the new smoking guidelines. Anyone caught smoking in undesignated areas or during undesignated times will have their smoking privileged revoked and will not be allowed to smoke any longer .These rules go into effect Wednesday 8/8/18. Facility policy titled, Smoking Policy -Grandfathered Residents was attached to the New Smoking Guidelines sheet that resident #27 signed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Non-Smoking and Tobacco-Free Facility Procedure, undated, showed, We are no longer a smoking facility. Residents that are grandfathered to smoke are the only ones permitted to engage in the activity in designated areas. Residents who smoke independently must keep their paraphernalia locked in the Medication room and check it in and out through the nurse/medication aide .No smoking materials or lighters kept on your person including lighters, matches or other igniting devices . Anyone caught smoking in undesignated areas or during undesignated times will have their smoking privileged revoked and will not be allowed to smoke any longer. These new rules went into effect Thursday, August 1, 2018 (MT) and Saturday, September 1, 2018 (IA/NE/SD). 46400 2. Review of a facility reported incident, dated 5/28/22, showed, [Resident #53] wandered into [resident #58's] room. [Resident #58] took a gait belt and struck [resident #53] across the face with the buckle end. During an interview on 11/21/22 at 9:29 a.m., Staff member G stated the day of the gait belt incident (5/28/22), she was getting ready to leave the unit for the day when she had to rush back into the room to help the single night aide and take the gait belt away. She stated resident #53 was bleeding, and you could still see a small scar on his face from the gait belt buckle. During an observation on 11/19/22 at 1:28 p.m., resident #53 was wandering in and out of various resident rooms and closing the doors behind him. There was a lack of staff supervision to intervene and redirect the behavior of the resident. Review of resident #53's nursing progress notes, dated 10/25/22, showed he approached the nurse with a large cut to his index finger. He was then sent to the E.R for stitches. Review of the facility reported incident findings, for resident #53's index finger injury, dated 10/28/22, showed a metal strip along the bathroom mirror was exposed and there was blood in the sink below.

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F 0741 Level of Harm - Actual harm Residents Affected - Many	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 46400 Based on observation, interview, and record review, the facility failed to ensure there were sufficient staff members present on the secure care unit to assist with resident care and supervision of residents, to include those with behavioral needs, for 11 (#s 14, 16, 17, 30, 31, 34, 48, 50, 53, 55, and 58) of 14 sampled residents. This failure led to repeated incidents of resident-to-resident abuse, and one incident of staff to resident abuse. Findings include: During an observation on 11/19/22 at 1:28 p.m., resident #53 was walking in and out of other resident rooms and closing the doors behind him. Staff were not around to be able to intervene or redirect resident #53's behavior. Review of facility reported incidents, dated 11/23/21 to 11/13/22, showed a pattern of resident to resident interactions on the secure care unit. During an incident on 12/9/21, resident #53 wandered into another room and inappropriately touched resident #16. During an incident on 5/28/22, resident #53 wandered into resident #58's room and was struck several times across the face with a gait belt buckle. During an incident on 11/13/22, resident #53 was found in resident #48's room with the door closed while they were lying on the ground striking each other. During an interview on 11/20/22 at 9:39 a.m., NF1 stated he didn't believe there were enough staff working on the secure care unit. He was angry about an incident that had happened to his family member. He stated, There's only one person back there [on the secure care unit] on nights (on shift working) with fourteen people (residents) walking around. During an interview on 11/21/22 at 9:29 a.m., staff member G stated, I'm not gonna lie there's only CNA back here at night. She then stated she felt it was too much (resident care) for one person. Staff member G stated they (facility) would give you another person (a PCA), but they are not hands on and can only hand out waters. Review of a facility staffing document, for 11/21/22, showed only one CNA was listed as working on the secure care unit that evening. 47003 During an observation on 11/19/22 at 3:22 p.m., resident #30 was in the TV room of the secure unit, and picked up an unplugged electronic device below the TV. Resident #30 carried the electronic device around the room, with the cord dangling for several minutes. There were two other residents in the room at that time. Resident #14 became agitated and told resident #30 to put the device down. There were two staff members present in the secure unit assisting other residents, neither staff member entered the TV room and redirected resident #30 from picking up or replacing the device on the table. Neither staff member noticed resident #14's increased agitation. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Many	During an observation and interview on 11/20/22 at 2:14 p.m., staff member G stated the facility expectation was the CNA assigned to work on the secure unit would watch all residents all the time. Staff member G stated it was not possible when several of the residents required direct CNA or nursing assistance with toileting or dressing, as well as the frequent redirection required for most of them. When staff member G left to aid another resident with ambulation, resident #14 was observed walking out of her room on the secure unit, and across the hall and into and out of another resident's room. No staff member observed or redirected resident #14. During an interview on 11/21/22 at 9:26 a.m., staff member G stated she usually worked on the secure unit, and in the time she had been employed at the facility, the night shift frequently had only one CNA working on the secured unit without a PCA or second CNA. Regarding an incident with resident #50 which happened on the night shift on 8/1/22, staff member G stated there had only been one CNA on the shift with no other CNA or PCA. Staff member G stated when working alone, during an emergency situation, there was no way for a CNA to request help from other staff members outside the secure unit other than using the telephone or yelling very loudly so other staff could hear. The main nursing station was approximately 30 feet from the closed double doors leading to the secure unit. During interviews on 11/21/22 at 8:20 a.m. and 10:03 a.m., staff member B stated two staff members were scheduled for the secure unit at all times, either two CNAs or a CNA and a PCA. The PCA was only allowed to do activities and non-direct patient care. If a staff member assigned to the secure unit called in ill, the facility used a call list to find another staff member to come in to fill the shift. If no one was found, it was up to the remaining staff in the facility to ensure at least two staff members were working on the secure unit at all times. Staff member B was unsure why there was only a statement from one CNA regarding direct contact with resident #50 on the night of the incident on 8/1/22. Staff member B stated beyond going through the call list to find another staff member to fill in, there was no actual policy or procedure for ensuring the secure care area had two employees working every shift. Staff member B stated the cause for the majority of the incidents occurring later in the day was most likely due to resident sundowning (typically a late day increase in confusion/behavior), and they had been trying to get more PCAs trained to do activities as the facility was trying to move away from hiring contract staff, but they had not specifically looked at adding additional resident supervision during that time. During an interview on 11/21/22 at 9:20 a.m., staff member M stated she was unsure where to find care plan interventions for resident behaviors or how to redirect specific residents on the secure unit if the CNA was with another resident and she had to intervene in an altercation between residents. Staff member M stated she would have to leave her area or room to find the CNA to ask her what to do. Review of 14 facility reported resident to resident and staff to resident incidents from 11/23/21 to 11/13/22 for the secure unit, which showed four incidents occurred between 2:50 p.m. and 6:30 p.m., and nine incidents occurred between 6:30 p.m. and 9:15 p.m. Review of the facility provided schedule showed that night shift staff worked from 6:00 p.m. to 6:30 a.m. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Many	Review of facility investigation documents into an incident with resident #50, and a staff member, on 8/1/22 showed, at 9:22 p.m., resident #50 ripped a closet door from its hinges and became physically aggressive towards staff member N who was aiding another resident with changing their clothes. This resulted in a physical and verbal altercation between resident #50 and staff member N. Staff Member N had to lock herself and the resident she was aiding in a bathroom until resident #50 stopped banging on the door to the bathroom. The investigation documents provided showed only staff member N had a direct interaction with resident #50 and gave a statement regarding the incident. The statement from staff member L relayed the events after she relieved staff member N from the secure unit. There were no other staff member statements regarding having directly witnessed the actual incident, as staff member N was working on the secure unit by herself. Review of the current care plans and MDS assessments for eight residents residing on the secure unit, showed: - Resident #14 - care plan, dated 11/10/22, required 1:1 staff supervision for aggressive/anxious behavior, monitor for rummaging through other's belongings, and assistance with ADLs, and showed, I like to go into other resident's rooms and attempt to help or comfort them . Interventions- Staff will redirect [Resident 14] away from entering other resident's rooms; - Resident #17 - care plan, dated 10/7/22, required extensive assistance of one staff for dressing, bathing, grooming, and toileting; - Resident #50 - care plan, dated 10/11/22, required supervision to limited assistance with dressing, bathing, grooming, and toileting; and, - Resident #58 - care plan, dated 10/31/22, required assistance of one staff for transport to group activities and location checks for wandering/elopement and assistance of two staff for relocation to other areas of unit for aggressive behavior; - Resident #30 - care plan, dated 8/27/22, needed monitoring for seizure activity and required limited to extensive assistance with bathing and dressing, and assistance with oral care; - Resident #31 - care plan, dated 8/24/22, required supervision to extensive assistance with toileting and ambulation, extensive assistance with transfers, and assistance with oral care; - Resident #34 - care plan, dated 10/20/22, required monitoring for sexually inappropriate behavior, supervision with transfers, bed mobility and ambulation, supervision with toileting, and assistance with oral care; and, - Resident #55 - Admission MDS, with an ARD of 8/28/22, required a one-person physical assistance with his activities of daily living, and was frequently incontinent of bowel and bladder.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 40068 Based on interview and record review, the facility failed to limit an as needed anti-anxiety medication order to 14 days or provide a rationale for extension of the medication for 1 (#27) of 5 sampled resident. Findings include: Review of resident #27's physician's order, dated 11/1/22, showed, LORazepam Tablet 0.5 MG. Give 1 tablet by mouth every 15 hours as needed for anxiety related to ANXIETY DISORDER, UNSPECIFIED (F41.9) Take one tablet at HS PRN (as needed) anxiety. During an interview on 11/21/22 at 2:57 p.m., staff member K stated the doctor would usually put an end date on the medication order if it was a PRN psychotropic medication. This would discontinue the medication and the doctor would need to reorder the medication, or write a rationale for the duration of the order. Staff member K stated it looked like the as needed lorazepam medication for resident #27 was missed.