STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275029	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yellowstone River Nursing and Rehabilitation	2115 Central Ave Billings, MT 59102

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on the interview and record review, the facility failed to ensure staff responded to resident needs timely for a resident requiring assistance with activities of daily living for 1 (#4) of 7 sampled residents. The deficient practice increased the risk for adverse psychosocial outcomes and skin integrity issues. The facility identified the failure of staff to respond timely, addressed and corrected the deficient practice before the survey, resulting in the findings of past non-compliance. Findings include:Review of a facility-reported incident, submitted to the State Survey Agency on 11/5/25, showed resident #4 contacted a family member over a concern about having to wait for staff to assist with personal care. Resident #4's family member attempted to call the facility. The facility did not respond. The family member contacted the local police, who arrived at the facility to do a welfare check on resident #4, due to the facility's lack of response.Review of the facility reported incident's investigative findings, submitted to the State Survey Agency on 11/12/25, showed resident #4 waited for personal care after being checked on by staff members, and had no psychosocial harm or skin breakdown based on assessments by staff. The findings showed the staff involved received discipline, with re-education provided to all nursing staff about the facility call light policy, nursing rounds at shift change, and abuse and neglect identification and prevention.During an interview on 12/30/25 at 9:00 a.m., staff member M stated she did not check on resident #4 when she started her shift at 6:00 p.m. on 11/4/25. Staff member M stated staff member I and staff member O went into resident #4's room at separate times after 6:00 p.m. to check on resident #4 due to her call light being turned on. Staff member M stated, she and staff member I, were assisting residents after dinner, and several residents required extensive assistance with care. Staff member M stated resident call lights were answered, in order of when the call light was turned on, along with their priority level of care needs due to some residents being at risk for falls. Staff member M stated that staff member O was passing medications to residents when her shift began at 6:00 p.m.During an interview on 12/30/25 at 12:15 p.m., staff member H stated she did not see resident #4's call light turned on after 5:30 p.m. on 11/4/25. Staff member H stated she checked on resident #4 during the day and changed resident #4's brief three times due to urinary and bowel incontinence. Staff member H stated the last time she saw resident #4, resident #4 did not request assistance with changing her brief. Staff member H stated she was catching up on charting around 5:30 p.m. and was at a nursing station during that time, while staff member L was in the dining room assisting residents with dinner. Staff member H stated there was a meeting held earlier in the year for all staff members, and staff were instructed to leave call lights on until a resident's request for assistance was completed.During an interview on 12/30/25 at 3:10 p.m., resident #4 stated she had her call light on for over four hours on 11/4/25 in the evening. Resident #4 stated she needed assistance from staff with having her brief changed due to urinary and bowel incontinence. Resident #4 stated staff members entered her room, did not turn off her call light, and did not return to assist her with personal care. Resident #4 stated she had a cow bell to use when she requested immediate assistance from staff, or when her call light was not working. Resident #4 stated she did not use the cow bell or call out loud for staff assistance on 11/4/25, although her call light remained on.During an interview on 12/31/25 at 7:38 a.m., staff member I stated she started her shift on 11/4/25 at 6:00 p.m. and did not receive information from staff member H that resident #4 needed assistance with changing her brief due to incontinence issues. Staff member I stated she entered resident #4's room to check on her due to her call light being on around 7:30 p.m. Staff member I stated she told resident #4 she would return with another staff member to assist with her personal care. Staff member I stated she and staff member M were responding to other residents who had call lights on, since they needed staff supervision and assistance. Staff member I stated she did not turn off resident #4's call light when she went into her room to check on her, because of information given during an all staff meeting to keep a resident's call light on until they were able to finish everything needed for the resident. Staff member I stated staff member O had also entered resident #4's room at a different time to assist her. Staff member I stated a police officer arrived in the facility and went to resident #4's room. Staff member I stated due to the police officer's arrival, she and staff member M were unable to assist resident #4 with personal care until he left resident #4's room.Review of a facility document titled, Past Calls, dated 11/4/25, showed resident #4's call light total response time was 4 hours and 41 minutes, with a starting time of 5:33 p.m.Review of resident #4's Minimum Data Set (MDS) with a Quarterly assessment reference date (ARD) of 9/13/25, Section GG - Functional Abilities, showed that GG0130. Self-Care was coded as, 1, for lower body dressing and toileting hygiene (the ability to maintain perineal