STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra of Billings	1807 24th St W Billings, MT 59102

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41652 Based on interview and record review, the facility failed to ensure a resident's provider and family were notified after a fall with injury, for 1 (#1); and failed to notify a resident's responsible party when a change of condition necessitated transfer to a hospital for 1 (#10) of 5 sampled residents. Findings include: 1. During an interview on 9/13/21 at 9:32 a.m., NF3 stated she had been made aware of a situation where resident #1 had sustained a fall with head injury on 9/9/21 at 6:00 p.m., and the provider and family were not notified until the morning of 9/10/21. NF3 stated she was also told the head wound had not been cleaned. During an interview on 9/14/21 at 12:20 p.m., NF6 stated she received a call on the morning of 9/10/21 from a nurse at the facility. NF6 stated the caller apologized for not notifying her of resident #1's fall sooner, as she was, so busy. During an interview on 9/14/21 at 1:40 p.m., staff member C stated she spoke with NF1 on the phone at 11:00 p.m. and had instructed NF1 to call resident #1's provider and family to let them know about the fall the resident had sustained earlier in the evening. Staff member C stated she did not know the calls had not been made as instructed until she arrived at the facility at 6:00 a.m. on 9/10/21. During an interview on 9/16/21 at 10:55 a.m., NF9 stated resident #1's provider was out of the office, but she had access to the note dictated on 9/10/21. NF10 stated the note indicated the on-call provider was not notified on 9/9/21 when the fall occurred. The provider noted she became aware of the fall when she arrived at the facility on 9/10/21 for resident rounds. The head wound, with dried, matted, blood, was concerning for a head injury, and the provider sent resident #1 to the emergency room for evaluation. A review of resident #1's nursing progress notes for 9/9/21 failed to show any documentation of provider or family notification after the fall at 6:05 p.m. on 9/9/21. Refer to F658 Services Provided to Meet Professional Standards for additional detail related to resident #1's fall. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 9/14/21 at 12:08 p.m., NF8 stated the facility had not notified her of resident #10's last two hospital admissions. NF8 stated resident #10 went to the wound clinic on 8/17/21 and was taken to the hospital from the wound clinic. The second hospital admission was on 8/27/21, and resident #10 had a fever. NF8 stated she found out about one of the admissions when the hospital called her asking questions. NF8 stated the facility called frequently about COVID-19 issues but did not call to notify her of changes in resident #10's condition necessitating admission to the hospital. A review of resident #10's nursing progress notes, dated 8/17/21 and 8/27/21, failed to show NF8, the resident's representative, had been notified of either hospital admission. A review of the facility's policy titled, Notification of a Change in Condition, dated 12/2019, showed the facility must immediately inform the resident's physician, and the resident's representative, of an accident resulting in injury, a need to alter treatment, or a decision to transfer the resident from the facility.

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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. 41652 Based on observation, interview, and record review, the facility failed to ensure a resident's call light was the appropriate type as identified in the care plan, and failed to ensure the call light was accessible for use by the resident, for 1 (#1) of 8 sampled residents. Findings include: During an observation on 9/13/21 at 11:55 a.m., resident #1 was observed lying in bed on her left side with her eyes closed. Resident #1 did not open her eyes or awaken to her name being said in a normal volume voice. Resident #1's push button call light was found on the floor, wedged between the bedside table and the wall. During an observation and interview on 9/13/21 at 3:18 p.m., resident #1 was lying in her bed and her call light was on the floor between the bedside table and the wall. Staff member I was asked why resident #1 did not have her call light. She said, Did it fall? It should be there. Staff member I picked up the call light from the floor and placed it near resident #1's hand. A review of resident #1's fall prevention care plan, dated 4/12/21, showed she was at high risk for falls due to visual impairment, an anxiety disorder, fatigue, and poor safety awareness. Interventions included the use of a pancake call light within the resident's reach. The pancake call light was a round pad approximately four inches in diameter. During an interview on 9/16/21 at 8:20 a.m., staff member C was asked why resident #1 did not have a pancake call light as identified in her care plan. Staff member C stated it must have been left in the room resident #1 occupied prior to her current room.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41652 Based on observation, interview, and record review, the facility failed to protect residents from neglect of care for the following areas: - when nursing failed to perform appropriate follow-up assessments, vital signs, neurological checks, and provider notification for a resident who sustained a fall with a head injury, for 1 (#1), - when a resident's dressing changes were not completed daily as ordered by the provider, for 1 (#7), - when direct care staff refused to assist a dependent resident with incontinence care which resulted in feelings of embarrassment and being unwanted, for 1 (#6), - when a resident's CPAP was not set up, per provider orders, after returning from a hospital admission for 1 (#2); and, - the facility failed to protect a resident from retaliation when a staff member failed to communicate with direct care staff the presence of a special meal brought by family to celebrate the resident's birthday, for 1 (#2) of 10 sampled residents. Findings include: 1. During an interview on 9/13/21 at 9:32 a.m., NF3 stated she had just received information regarding possible neglect related to resident #1's fall on 9/9/21 and follow-up nursing care. NF3 stated she had been told the provider and family had not been notified about the fall until 9/10/21. She also stated she had been told the resident's head wound had not been cleaned. During an interview on 9/14/21 at 12:20 p.m., NF6 stated she received a call from a female travel nurse on the morning of 9/10/21. NF6 stated the nurse apologized for not calling sooner and told her resident #1 had fallen the previous evening, cutting her head; but that she, was fine. NF6 stated she received a call from the facility at approximately 10:20 a.m. informing her the provider was concerned about a head injury and was transferring resident #1 to the emergency room for evaluation. During an interview on 9/14/21 at 1:40 p.m., staff member C stated she was notified regarding resident #1's fall at 11:00 p.m. on 9/9/21. Staff member C stated she instructed NF1 to notify the provider and the family, and to start neurological checks on resident #1. Staff member C stated when she arrived at the facility on 9/10/21 at 6:00 a.m., she found out NF1 had not done the notifications or neurological checks as instructed. Staff member C stated the subsequent investigation did not identify the reason for NF1's lack of action, and did substantiate neglect of care by NF1. During an interview on 9/16/21 at 10:55 a.m., NF10 stated she was aware of resident #1's fall and had access to the provider's note from 9/10/21. NF10 stated the note showed no provider had been notified regarding the fall on 9/9/21 until rounds on 9/10/21. The note showed the provider was not able to observe the head wound because of dried, matted blood on her head and blood on her pillow, and was concerned about a head injury. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A request was made on 9/14/21 at 3:50 p.m., for any documentation related to resident #1's fall and follow-up care. The only documentation provided was two nursing progress notes describing the provider's visit and subsequent transfer to the emergency room . See F658 for additional details related to resident #1's fall and follow-up care. A review of resident #1's nursing progress notes, dated between 9/9/21 at 6:00 p.m. and 9/10/21 at 10:00 a.m., failed to show a fall, notifications to the provider or the family, any assessments related to the circumstances of her fall, or any post fall assessments. A review of resident #1's nursing progress note, dated 9/10/21 at 11:20 a.m., showed the resident was examined at 10:30 a.m. by a provider. The note showed provider orders were received at 10:40 a.m. to send resident #1 to the emergency room for evaluation and a CT scan of her head. NF6 was notified of the transfer. At 11:20 a.m. resident #1 was transferred to the emergency room , and was, very lethargic, slow to respond, [complained of] pain pointing to head. Able to follow very simple direction after several prompts. 2. During an interview on 9/15/21 at 3:27 p.m., staff member A stated NF11 called the facility and made an allegation of neglect regarding missed dressing changes over the weekend of 6/19/21 and 6/20/21. As part of the investigation, staff member A stated several other residents were identified as at risk for having missed dressing changes. Staff member A stated resident #7 was identified as one of these residents. Staff member A stated her investigation failed to show resident #7 had missed any dressing changes on either 6/19/21 or 6/20/21. A review of resident #7's Treatment Administration Records, dated 5/2021 and 6/2021, showed 5/29/21, 6/8/21, 6/9/21, 6/15/21, and 6/18/21 did not have a check mark and initials which showed the treatment had been completed. A review of resident #7's nursing progress notes, dated 5/29/21, 6/8/21, 6/9/21, 6/15/21, and 6/18/21, failed to show any documentation about resident #7's dressing changes. During a follow-up interview on 9/16/21 at 8:20 a.m., staff member A stated when she investigated the issue of missed dressing changes, she only looked at 6/19/21 and 6/20/21. Staff member A stated she did not look at any other days and did not identify the five missed days noted above. Staff member A stated she should have, looked at the bigger picture, and did not identify other dates which were missed and why they were missed. 3. During an interview on 9/13/21 at 12:11 p.m., resident #6 stated she had submitted a grievance in July 2021 alleging neglect by a CNA who refused to change her soiled brief. Resident #6 stated she had turned on her call light because she was soiled and needed to be changed. Resident #6 stated the CNA told her she would need to wait until the next shift. Resident #6 stated she did wait until the night shift came, and the CNA was a male. Resident #6 stated she was embarrassed to have him clean her up. Resident #6 described a more recent incident, on 9/5/21, which involved the same CNA. The more recent incident occurred when resident #6 put her call light on at 4:30 p.m. requesting to have her brief changed and to get ready for bed. Resident #6 stated she saw the CNA assisting other residents, but not her. After she had waited approximately 45 minutes, resident #6 stated she called staff member A to report the incident. Staff member A told her she would take care of it. Resident #6 stated she did not want the CNA to take care of her anymore. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/15/21 at 10:08 a.m., staff member G, accompanied by staff member C, stated part of the corrective action for the CNA involved in the 9/5/21 incident had been to move her to another unit so she would not be taking care of resident #6. A review of the State Survey Agency's online incident tracking system showed an allegation of neglect was submitted on 7/6/21, by the facility. The submission showed resident #6 made an allegation of neglect related to a CNA refusing to assist her. The subsequent investigation substantiated neglect because the resident was left in a soiled brief for 45 minutes. 4. During an interview on 9/15/21 at 4:30 p.m., staff members A and C discussed grievances submitted by NF4 on behalf of resident #2. One of the grievances was submitted because resident #2's CPAP machine was not set up for use when she returned from a hospital stay on 8/9/21. Staff member A stated when resident #2 returned from the hospital on 8/9/21, she had a new bariatric bed. Staff member A stated the bed took up more room than a regular bed and made the power outlets difficult to access. Staff member C stated furniture would have needed to be moved. Staff member C stated resident #2 was moved to a larger room where the electrical outlets were accessible, and the CPAP could be plugged in. Staff member C stated the CPAP was set up and ready for use on 8/10/21. A review of the State Survey Agency's online incident tracking system showed an allegation of neglect was submitted by NF4 on 8/11/21. The alleged neglect on the part of the facility was for not setting up resident #2's CPAP on 8/9/21. The subsequent investigation substantiated the neglect. 5. During an interview on 9/13/21 at 9:32 a.m., NF3 stated she was aware of an incident which had occurred approximately two weeks ago. NF3 stated a family member had brought a birthday dinner for resident #2. She stated the meal remained at the nurse's desk for a while. When resident #2 was called by her family to see if she enjoyed her birthday dinner, resident #2 told them she had not gotten anything special. During an interview on 9/16/21 at 8:20 a.m., staff members A and C stated a family member brought resident #2 a surprise birthday dinner. As the facility was on lockdown because of a COVID-19 outbreak, the family member called beforehand to explain the dinner was a surprise for resident #2's birthday. The dinner was left with staff member S at the front desk. Staff member A stated staff member S called the unit to let them know there was something for resident #2. Staff member A stated staff member S, not able to reach the unit by telephone, delivered the bag to the empty nurse's station on the unit. Staff member A stated as there was no name on the outside of the bag, the staff on the unit did not look into the bag. Staff member A stated when the family member called later, resident #2 still had not received the bag. The conclusion of the investigation was staff member S could and should have done more to facilitate resident #2 getting her birthday dinner, and determined staff member S was retaliating because of a previous incident with resident #2's family. A review of the State Survey Agency's online incident tracking system showed an incident was submitted by the facility on 9/10/21 which substantiated the allegation of retaliation by staff member S. A review of the facility's policy titled, Abuse and Neglect, last revision date 5/15/19, showed neglect to be the failure to provide necessary and adequate (medical, personal, or psychological) care, and All retaliation in any manner against residents for reporting abuse is considered abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41652 Based on observation, interview, and record review, the facility failed to thoroughly investigate allegations of neglect related to missed wound dressing changes for 1 (#7) of 4 sampled residents. Findings include: During an interview on 9/15/21 at 3:27 p.m., staff member A stated she received a call from a provider on 6/21/21 alleging neglect with regard to dressing changes for a resident not associated with this complaint. Staff member A stated the investigation involved dressing changes which should have been done over the previous weekend (6/19/21 and 6/20/21). Staff member A stated as part of her investigation she identified several other residents who may been affected by the missed dressing changes. Upon completion of the investigation, staff member A stated no dressing changes were missed on 6/19/21 and 6/20/21 for the residents investigated and the allegation of neglect was not substantiated for the specific days identified by the provider who made the initial allegation. Staff member A stated she did not look at any other dates to see if dressing changes had been missed. A review of resident #7's Treatment Administration Record, dated 5/2021 and 6/2021, showed no check mark or initial for dressing changes due on 5/29/21, 6/8/21, 6/9/21, 6/15/21, and 6/18/21. A review of resident #7's nursing progress notes, dated 5/29/21, 6/8/21, 6/9/21, 6/15/21, and 6/18/21, failed to show any documentation regarding dressing changes or why they may have been missed. During a follow-up interview on 9/16/21 at 8:20 a.m., staff member A stated she could not be sure if other dressing changes were missed because she only looked at documentation for 6/19/21 and 6/20/21. Staff member A stated a thorough investigation would have looked at, The bigger picture, in order to determine if there was neglect for the other residents investigated, specifically resident #7. A review of the facility's policy titled, Abuse and Neglect, last revision date 5/15/19, showed investigations should include interviewing any person who might have had knowledge of the allegation, focus on determining if abuse or neglect occurred, and thoroughly documenting the investigation.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41652 Based on interview and record review, the facility failed to ensure contracted nursing staff used professional judgement when caring for a resident taking an anticoagulant medication, who sustained a fall with a head injury, increasing the risk of harm due to a delay in treatment of a more serious, undiagnosed head injury, for 1 (#1); and the facility failed to ensure nursing staff administered diuretic medications as ordered by the provider resulting in a worsening of the resident's fluid retention, for 1 (#2) of 3 sampled residents. Findings include: 1. During an interview on 9/13/21 at 9:32 a.m., NF3 stated she had been notified resident #1 had fallen and injured her head at approximately 6:00 p.m. on 9/9/21. NF3 stated she had been told the wound had not been cleaned as of the morning of 9/10/21. The provider had not been notified on 9/9/21, regarding the fall with injury, and was not aware of the fall until she arrived at the facility on 9/10/21 to do resident rounds. During an interview on 9/14/21 at 12:20 p.m., NF6 stated she was notified of resident #1's fall early on the morning of 9/10/21. NF6 stated she was, in shock, when the nurse apologized for not calling the evening before. NF6 stated the nurse told her she did not call because she was, so busy. NF6 stated she called the facility back about 10:00 a.m. to check on resident #1 and found out the resident had not been seen by a provider yet. NF6 stated someone from the facility called her at about 10:20 a.m. to say the provider had a concern for a head injury and was sending the resident to the emergency room for an evaluation. During an interview on 9/14/21 at 1:17 p.m., staff member R stated the facility's process for handling falls included protecting the resident from further injury, performing vital signs and neurological checks as part of a resident assessment, and notifying the provider, family, DON, and administrator. Staff member R stated an incident report and documentation associated with the Fall Check List were completed and then forwarded to the unit manager for review. During an interview on 9/14/21 at 1:40 p.m., staff member C stated the fall protocol included a resident assessment, vital signs, and neurological checks if the fall was unwitnessed or if there was a head injury. Staff member C stated she was notified by NF1 at 11:00 p.m. of the fall sustained by resident #1 at 6:05 p.m. on 9/9/21. Staff member C stated she told NF1 to notify the on-call provider, the resident's family, and to begin performing neurological checks on resident #1. Staff member C stated when she arrived in the facility at 6:00 a.m. on 9/10/21, she found out NF1 had not done the notifications as instructed and had not been performing neurological checks on resident #1. Staff member C stated NF1 was immediately suspended, and the subsequent investigation showed there had been a miscommunication between NF1, the night shift nurse, and NF2, the day shift nurse. Each nurse believed the other was performing the required notifications. When asked why NF1 did not document resident #1's vital signs and neurological checks, staff member C stated, I don't know why it (vital signs and neurological checks) didn't happen. Staff member C stated there was a binder at each nurse's station which contained training documents including falls management. Staff member C stated during the investigation of resident #1's fall and subsequent care, the facility identified a gap regarding orientation and training of agency or contract nursing staff. Staff member C stated the facility had started a performance improvement project in response the the findings of this investigation. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's policy titled, Falls Management, dated 11/2019, showed post fall resident management included a complete assessment, obtain vital signs, obtain neurological checks with evidence of an injury to their head, contact the provider and the resident representative and document in the medical record. A review of the facility's Fall Check List, not dated, provided by staff member R on 9/14/21, showed the following tasks were to be completed after a resident fall: -Contact DON, -Contact provider, -Contact family, -Fill out Fall Scene Investigation (paper form), -Complete Risk Management in electronic medical record, and -Initiate neurological checks if resident hits their head or if the fall is unwitnessed. A request was made to staff members A and C on 9/14/21 at 3:50 p.m. for any documentation associated with resident #1's fall and post fall care. The only documentation received prior to the end of the survey was the two nursing progress notes identified below. No documentation of the Fall Check List, the Fall Scene Investigation, resident #1's assessments, vital signs, or neurological checks was provided prior to the end of the survey. A review of resident #1's nursing progress note, dated 9/10/21 at 11:20 a.m., showed the resident was examined at 10:30 a.m. by a provider. The note showed provider orders were received at 10:40 a.m. to send resident #1 to the emergency room for evaluation and a CT scan of her head. NF6 was notified of the transfer. At 11:20 a.m. resident #1 was transferred to the emergency room , and was, very lethargic, slow to respond, [complained of] pain pointing to head. Able to follow very simple direction after several prompts. A review of resident #1's nursing progress note, dated 9/10/21 at 4:59 p.m., showed she returned from the emergency room , x-rays of her head, right hip and right hand were negative for injury. Resident #1 was, . alert, oriented times one only, disoriented and argumentative. Easily becoming agitated, wheeling self in [wheelchair]. Knocking into furniture, unable to redirect as she continues argumentative. 2. During an interview on 9/13/21 at 2:00 p.m., resident #2 stated the nurses have not been giving her pills on time and it has caused her to gain weight. Resident #2 stated it was an ongoing problem. On 9/15/21 at 10:26 a.m., the surveyor received a voicemail from NF4 regarding the issue of proper administration of certain medications. NF4 stated he had spoken with resident #2's provider, staff member T, and the improper administration of specific medications which was raising a health issue for resident #2. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/16/21 at 11:21 a.m., staff member T stated there was an issue with the administration of metolazone and bumetanide. Staff member T stated metolazone was a thiazide diuretic and bumetanide was a loop diuretic, and it was imperative the metolazone was given no more than 30 minutes before the bumetanide. If the medications were given more than 30 minutes apart, the potentiating effect was lost. Staff member T stated this had been explained to nursing several times, and the order specified the metolazone was to be given 30 minutes before the bumetanide. Staff member T stated the facility's inability to give the medications as ordered had caused resident #2 to gain weight. Staff member T stated the order specified metolazone was to be given 30 minutes before bumetanide to have the proper effect. A review of resident #2's Medication Administration Audit Report, dated 9/16/21, showed the following: -7/7/21 metolazone 5 mg given at 7:25 a.m., bumetanide 2 mg given at 8:41 a.m., 76 minutes apart, -7/9/21 metolazone 5 mg given at 8:49 a.m., bumetanide 2 mg given at 9:57 a.m., 68 minutes apart, -9/5/21 metolazone 5 mg given at 8:38 a.m., bumetanide 2 mg given at 9:48 a.m., 70 minutes apart, -9/7/21 metolazone 5 mg given at 8:38 a.m., bumetanide 2 mg given at 9:50 a.m., 72 minutes apart, -9/11/21 metolazone 5 mg given at 9:11 a.m., bumetanide 2 mg given at 9:54 a.m., 43 minutes apart, -9/12/21 metolazone 5 mg given at 9:25 a.m., bumetanide 2 mg given at 10:21 a.m., 56 minutes apart, and -9/14/21 metolazone 5 mg given at 8:15 a.m., bumetanide 2 mg given at 9:55 a.m., 100 minutes apart. A review of resident #1's weights showed the following: -8/9/21, return from hospital admission, 294 pounds, -9/11/21, 315.5 pounds, and -9/15/21, 310.5 pounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra of Billings	1807 24th St W 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. 41652 Based on observation, interview and record review, the facility failed to ensure dependent residents received showers or baths as per their care planned frequency, for 2 (#s 2 and 3) of 5 sampled residents. Findings include: 1. During an interview on 9/13/21 at 9:32 a.m., NF3 had recieved a concern from NF5 regarding resident #3's care. NF3 stated she was told by NF5 that resident #3 did not want anything done with the concerns voiced as he did not want, to rock the boat. During an interview on 9/13/21 at 10:13 a.m., NF5 stated she was concerned about resident #3 not receiving assistance with his personal cares and hygiene. NF5 stated resident #3 had a stroke a few years ago and needed help with taking care of himself. NF5 stated resident #3 was reluctant to ask for help with personal hygiene as he did not want to, cause waves. During an observation and interview on 9/13/21 at 12:04 p.m., resident #3 was able to move his wheelchair using his left hand and foot. However, resident #3's right hand remained in his lap and was not used to move his wheelchair. Resident resident #3 stated he did not want to talk any longer when he was asked about his care, and asked the surveyor to leave. Resident #3 stated talking about these things, upset him. A review of resident #3's Quarterly MDS, with an ARD of 8/3/21, showed he was not cognitively impaired, required limited assistance with personal hygiene, and was totally dependent on the assist of one staff member for bathing. A review of resident #3's ADL care plan, dated 3/2/19, showed, I prefer two showers per week. I like Tuesdays and Saturdays, but I am ok with what days work with the shower aide. A review of resident #3's shower completion documentation, dated 6/1/21 through 9/13/21, showed the following: -no shower between 6/1/21 and 6/9/21, 8 days, -no shower between 6/9/21 and 6/22/21, 12 days, -no shower between 6/22/21 and 6/29/21, 7 days, -no shower between 6/29/21 and 7/13/21, 14 days, -no shower between 7/13/21 and 7/27/21, 13 days, and -no shower between 8/28/21 and 9/9/21, 12 days. 2. During an interview on 9/13/21 at 11:30 a.m., resident #2 stated one particular CNA did not want to come in her room to help her. Resident #2 used call light to summon someone to assist her to the bathroom using the sit to stand lift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra of Billings	1807 24th St W Billings, MT 59102

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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	During an interview on 9/14/21 at 9:27 a.m., NF4 stated he had concerns with bathing and answering of call lights for resident #2. NF4 stated because it requires two staff to assist resident #2, it made providing timely care more difficult. NF4 stated he had heard the excuse of short staffing from both administration and direct care staff. A review of resident #2's Significant Change MDS, with an ARD of 8/2/21, showed she had moderately impaired cognition, required limited assistance with personal hygiene, and was totally dependent on assistance from staff for bathing. A review of resident #2's ADL care plan, dated 7/14/21, showed, I will need assistance with and prefer to get 2 to 3 showers per week. A review of resident #2's shower completion documentation, dated 6/1/21 through 9/13/21, showed the following: -no shower between 6/1/21 and 6/15/21, 14 days, -no shower between 7/2/21 and 7/13/21, 11 days, -no shower between 8/17/21 and 8/24/21, 6 days, and -no shower between 9/7/21 and 9/13/21, 6 days.