

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER Bella Terra of Billings		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>44770</p> <p>Based on observation and interview, the facility failed to provide a comfortable and safe environment for 3 (#s 12, 17, and 43) of 15 sampled residents. The residents were given space heaters to heat their rooms because the radiators were not working. This deficient practice caused resident #12 to complain of being cold, resident #17 to complain of being cold, resident #43 to complain of freezing and having a headache and sore throat, and the heaters had the potential to cause harm to the residents. Findings include:</p> <p>During an interview on 2/14/22 at 3:56 p.m., resident #12 stated, The heater only works part of the time.</p> <p>During an interview on 2/15/22 at 8:45 a.m., resident #12 stated, It got cold in here last night. They took my heater away and didn't bring it back. Probably because you are here.</p> <p>During an interview on 2/15/22 at 10:03 a.m., resident #43 stated, I didn't have any heat in this room for three days, we had portable heaters in here until last night and they took it away. I'm freezing in here. I have a terrible headache and sore throat. I'm just so cold and it was so cold in here last week.</p> <p>During an interview on 2/15/22 at 10:12 a.m., staff member B stated, The space heaters were removed yesterday because of life safety code.</p> <p>During an interview on 2/15/22 at 2:40 p.m., staff member A stated, There is no policy for portable heaters because they are not to be used.</p> <p>During an interview on 2/16/22 at 8:42 a.m., staff member CC stated, The heaters were here from around October (2021). Whenever it got cold.</p> <p>During an observation and interview on 2/16/22 at 2:32 p.m., staff member E came down the 300 hall checking temperatures of the radiators. He stated that he was working on the heat. He said that the system was producing heat, but it was not coming out of the radiators. The thermostat read 71 degrees Fahrenheit at the nurses' station, and it felt colder at the end of the hall by the door to the outside.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 2/16/22 at 2:34 p.m., resident #17 was in her room laying on the bed wearing her robe as a blanket, she said, It is cold in here because they had to take the heaters out because the state inspectors are here.</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>44770</p> <p>Based on interview and record review, the facility failed to:</p> <ul style="list-style-type: none"> - Provide ordered dressing changes for 2 (#s 5 and 212) of 3 sampled residents. For #5, the resident missed a wound care appointment, which was not rescheduled, and the wound was not treated as ordered. For resident #212, a wound went untreated, and worsened, requiring antibiotics, and the resident had pain from the wound. - Nursing staff neglected to send 1 (#12) resident to the emergency department when the resident requested to be sent, and the resident was later diagnosed with lower lobe pneumonia and antibiotics to treat the infection. - Failed to protect 1 (#4) of 1 sampled residents from two incidents of verbal abuse by staff. The failure, and action taken by the facility, did not ensure resident protection after the first incident of verbal abuse for resident #4, and it occurred again. Findings include: <ul style="list-style-type: none"> 1. A record review of a facility reported incident for a neglect allegation, dated 9/19/21, showed, On 9/17/21, it was reported by the wound nurse that the dressing to resident, [#5], was dated 9/9/21. Resident's dressing is scheduled to be changed on Tuesdays and Fridays. Per the schedule the dressing should have been changed on 9/10 and 9/14. The allegation of neglect was substantiated by the facility. <p>During an interview on 2/16/22 at 9:56 a.m., staff member A stated she investigated the incident and found that resident #5 missed her appointment for wound care because she was not ready to go when the bus was ready to take her. The driver had another resident to take to an appointment and did not have time to wait for the nurses to get the resident ready for her appointment. Resident #5 would have had her dressing changed at that appointment, but since she did not go, the dressing was not changed. The TAR did not prompt the nurse to change the dressing. Staff member A stated they have changed the process so that on wound care appointment days it will need to be documented if the clinic does the dressing change or if the nurse does the dressing change. Although the resident did not attend the scheduled appointment, the facility staff did not ensure the resident's skin care needs were addressed related to the dressing change.</p> <p>A record review of resident #5's EMR, Skin Wound Note, dated 9/7/21, showed, Resident right lateral outer and calf are healing with no signs of infection noted, redness is resolved, area is light pink, will continue with current treatment order for protection. This was prior to the event of the resident not attending the scheduled appointment.</p> <p>A record review of resident #5's EMR, Communication with Resident Family, dated 9/17/21, showed, Family was notified of resident missing wound care appointment on 9/14/21. Due to the resident missing her appointment her wound care to the right calf was not completed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an interview on 2/14/22 at 3:56 p.m., with resident #12 and NF3, resident #12 stated, I needed to go to the hospital (1/16/22) because I couldn't breathe and the nurse (staff member II), told me 'We don't do that here.' NF3 stated she did not get a phone call about it, and that they diagnosed him (resident #12) with left lower lobe pneumonia. NF3 did not find out about it until the next day. Resident #12 stated, The doctor saw me here the next day during his regular rounds. I was given a nebulizer and a steroid. NF3 stated, in November, around the 11th (2021) she saw protective dressings on his feet that had been on since he had been in the hospital. NF3 stated the CNA gave him a shower with the dressings on, and then the water from the wet dressings soaked his socks and shoes. NF3 went to talk to the nurse to see if she could take the dressings off and was told by the nurse, I don't care what you do.</p> <p>During an interview on 2/15/22 at 2:41 p.m., staff member A stated, We follow the resident rights on change in condition, if he (resident #12) wanted to go to the hospital, he should have been sent.</p> <p>During an interview on 2/16/22 at 8:36 a.m., staff member CC stated if a resident tells her they need to go to the hospital, she would check the residents' vitals, call the MD, and provide any interventions needed for the resident. Staff member CC stated, But if the resident is requesting to go to the emergency room then I would send them.</p> <p>A review of resident #12's medical record showed an x-ray, dated 1/17/22, with clear lungs, and the lab testing was negative for influenza and Covid 19. On 1/24/22, a new x-ray showed the resident had left lower lobe pneumonia, and a Z pack (azithromycin) was ordered, along with prednisone 40 mg for 5 days, and Duo Neb three times a day, to be started 1/24/22. Review of resident #12's MAR showed the medications were not started until 1/25/22.</p> <p>During an interview on 2/16/22 at 2:38 p.m., resident #12 stated, I did tell the CNA and the dayshift nurse that the night nurse told me I couldn't go to the hospital. But nobody did anything about it.</p> <p>3. A record review of a facility reported incident for a neglect allegation, dated 9/20/21, showed, On 9/20/21, it was reported by night shift that the dressing to resident, [#212], was dated 9/8/21 . An allegation of neglect has been submitted . the allegation of neglect is substantiated. According to the facility reported incident the facility found that a nurse falsified a record, documenting she had changed the dressing on 9/14/21, but she had not, and on 9/17/21 another nurse documented on the TAR that she changed the dressing because she thought that the wound care nurse had done the dressing change, but the dressing was not changed on 9/17/21 either.</p> <p>During a telephone interview on 2/15/22 at 4:15 p.m., resident #212 stated, the wound was now healed but he remembered the incident. Resident #212 stated, It was very painful. I had a hell of a time for it to heal. It was healed once then it got a blister under the dressing. It took it months for it to heal after they found it like that.</p> <p>During an interview on 2/16/22 at 9:56 a.m., staff member A stated it was her understanding that resident #212's wound was healed and then the nurse placed a dressing on it to protect it. When it was discovered that the protective dressing did not get changed on schedule, when they took the protective dressing off they found a new blister.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/17/22 at 7:55 a.m., staff member A stated, [Staff member HH] was terminated for falsifying documentation. She was educated on wound care. [Staff member HH] admitted that she falsified the document that she had changed the dressing but then didn't do it. That is all I remember about that.</p> <p>A record review of resident #212's TAR, dated August 2021, showed, the protective dressing was changed on 8/4/21, 8/14/21 and 8/18/21, but it was not changed as ordered on 8/7/21 or 8/11/21. The bandage was left on and unchanged for 10 days.</p> <p>A record review of resident #212's TAR, dated September 2021, showed, the protective dressing was changed on 9/3/21, 9/21/21 and 9/24/21, but was not changed as ordered on 9/7/21, 9/10/21, 9/14/21 or 9/17/21. The bandage was left on and unchanged for 14 days.</p> <p>A record review of resident #212's skin/wound note, dated 7/28/21, showed, the left heel wound was healed and a protective dressing applied.</p> <p>A record review of resident #212's skin/wound note, dated 9/20/21, showed, the left heel dressing was not changed per physician order. There was no documentation to reflect any changes in the wound.</p> <p>A record review of resident #212's antibiotic note, dated 9/22/21, showed, Lt (left) heel wound, antibiotics x 5 days, dressing change. Date of infection 9/20/21. The wound required antibiotics at this point.</p> <p>A record review of resident #212's Health Status Note, dated 9/23/21, showed, wound to heel measures 0.5 x 3.5 x 0.1 serosanguinous drainage noted. This wound is due to resident receiving a shower with foam heel protector in place and was not changed per provider orders. There was no documentation to reflect the stage of the wound/ulcer.</p> <p>32997</p> <p>4. Review of two facility reported incidents, dated 10/20/21 and 8/2/21, for verbal abuse toward resident #4 were investigated.</p> <p>a. On 8/2/21 an allegation of verbal abuse was reported. A CNA overheard a nurse tell resident #4 Maybe it would be better if you broke something, and we can get rid of you for a few weeks. You don't let me get my work done and I'm going to kill someone.</p> <p>Review of resident #4's clinical record showed, at the time of the incident, the resident was moderately cognitively impaired with Alzheimer's Disease, and vascular dementia.</p> <p>The facility did substantiate verbal abuse of resident #4. The nurse was suspended pending investigation. The nurse received a written disciplinary action, and was educated on customer service, and resident rights.</p> <p>b. On 10/20/21 a CNA was overheard saying, Don't you comprehend what I am saying (resident name). This was said in a harsh tone to Resident #4. Resident #4 was heard to respond with I am a pain in the butt.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility did substantiate verbal abuse of resident #4. The CNA was suspended pending investigation. The CNA was disciplined by the facility, and educated on customer service.</p> <p>A review of the facility's policy, Abuse and Neglect, dated May 2019, reflected:</p> <p>Policy Statement:</p> <p>It is the policy of the facility to provide professional care and services in an environment that is free from . neglect .</p> <p>Neglect is the failure to provide necessary services and adequate (medical, personal or psychological) care . failure to care for a person in a manner, which would avoid harm .Staff may be aware or should have been aware of the service the resident requires, but fails to provide that service.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>44770</p> <p>Based on interview and record review the facility failed to fully investigate alleged neglect for 2 (#s 5 and 212) out of 2 sampled residents. Findings include:</p> <p>1. A record review of a facility reported incident, dated 9/19/21, showed resident #5 had not had her wound dressing changed for seven days. Resident #5's dressing was scheduled to be changed on Tuesdays and Fridays. Per the schedule, the dressing should have been changed on 9/10/21 and 9/14/21, but was not. The dressing did not get changed because resident #5 missed her wound care appointment as she was not ready to go when the driver arrived, and he had other residents to take to appointments. The nursing documentation did not prompt the nurse to do the dressing change since it otherwise would have been done at the appointment. (See F600 for details.) The nurse on duty failed to ensure measures were taken for the resident's wound treatment that was missed.</p> <p>A review of a facility document titled, Verification of Investigation, dated 9/17/21, showed the form was not filled out completely. There were four areas to fill out, provide a detailed description of event/allegation, assessment of resident/describe injury, resident interview summary, and immediate resident protection initiated. Only the first section, Provide detailed description of event/allegation, had anything written in it. The rest of the form was blank, other than a check mark in the box labeled YES for immediate resident protection initiated, but the form failed to describe the action provided for the resident or other investigation details.</p> <p>2. A record review of a facility reported incident, dated 9/20/21, showed, resident #212 had not had his protective dressing changed for 14 days causing a wound to develop.</p> <p>A record review of resident #212's TAR, dated September 2021, showed, the protective dressing was changed on 9/3/21, 9/21/21 and 9/24/21 but was not changed as ordered on 9/7/21, 9/10/21, 9/14/21 or 9/17/21. Showing the dressing did not get changed for 14 days.</p> <p>A record review of resident #212's Health Status Note, dated 9/23/21 showed, wound to heel measures 0.5 x 3.5 x 0.1 serosanguinous drainage noted. This wound is due to resident receiving a shower with foam heel protector in place and was not changed per provider orders. (See F600 for details.)</p> <p>There was no Verification of Investigation form completed for this facility reported incident.</p> <p>During an interview on 2/16/22 at 9:49 a.m., staff member A stated, When I do my investigations, we report first then we suspend staff if we need to. We get statements from those involved or from other residents as well. We look at documentation that is pertinent to that investigation, notify family and physician if needed. I'll do the investigation if there is abuse or neglect. [Staff member JJ] was the DON at the time of the incidents, and she was handling those (resident #s 5 and 212's facility reported incident investigations). There is a form that we fill out that guides us through the process [staff member JJ] was not very faithful using those forms. So, the form should guide the process for the follow up. It is a tool that is created for (agency name) so you get to the resolution to the problem. But [staff member JJ] never finished them. Staff member A stated she looked at her QAPI notes for that time frame and there was nothing specific in them that showed the facility talked about the incidents or how to change the process to ensure investigations were completed.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>45448</p> <p>Based on interview and record review, the facility failed to complete accurate assessments for 1 (13) of 4 sampled residents. This deficient practice had the potential to affect resident care and safety as it inaccurately depicted the residents' care needs. Findings include:</p> <p>During an interview on 2/15/22 at 1:17 p.m., resident #13 stated his pressure ulcer was healed sometime in January 2021. He was no longer going to the wound clinic.</p> <p>During an interview on 2/16/22 at 12:37 p.m., staff member EE said, I spoke with the wound nurse, and the resident still has a small open wound, it is not fully healed. The wound clinic said the wound is healed.</p> <p>A record review of resident #13's care plan, with an initiation date of 5/20/21, showed:</p> <ul style="list-style-type: none"> . Weekly monitoring of wounds by wound nurse or designee -assessment -recommendations -measurement <p>Date Initiated 7/23/21 .</p> <p>A review of the facility's LGHC Skin Evaluation, completed by staff member GG, for resident #13 on 1/12/22 and 1/19/22, showed:</p> <ul style="list-style-type: none"> .6. Pressure Ulcer <p>site; 55) Right gluteal fold, Type; Pressure. The area for measurement was left blank.</p> <p>Staff member GG did not document measurements for resident #13's pressure ulcer or recommendations for treatment as ordered by the physician.</p> <p>A review of the facility's LGHC Skin Evaluation, done by staff member GG, for resident #13 on 2/4/22 and 2/12/22 showed:</p> <ul style="list-style-type: none"> . 5. Resident has alteration in skin integrity: No <p>Staff member GG's documentation showed resident #13 no longer had an alteration of skin integrity.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Wound Assessment Detail Report, dated 2/14/22, completed by staff member MM, showed a picture of a right gluteal upper posterior thigh wound with measurements of 0.3 X 0.4 X 0.1 (L x W x D). A review of staff member MM's progress note, dated 2/16/22 at 12:56 p.m., showed, Upon wound assessment today writer measured a small opening of 0.2cm (L) x 0.2cm (W). Scar tissue noted around previous wound. No exudate. Will continue with current treatment.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997</p> <p>Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed and implemented, and that it included beneficial individualized focus areas, goals, and interventions for a resident with disruptive behaviors, for 1 (#4), of 4 sampled residents, and the resident's quality of life, and that of others was negatively affected, and the resident had a diagnosis of Alzheimer's/Dementia, and had been at the facility for an extended period of time. Findings include:</p> <p>During an interview on 2/16/22 at 9:11 a.m., NF2 said the facility did not provide adequate care for resident #4. NF2 said the facility had a recent care plan meeting for resident #4, and all disciplines were supposed to attend. NF2 said nursing should have been in attendance since resident #4's behaviors were all related to her medical problems. NF2 said she knew the facility did not want resident #4 in the facility due to all the behavior problems, but nursing would not document her behaviors consistently, good and bad, so the neuropsychologist could make a determination on the approaches and medications for the resident to improve her quality of life. NF2 said when she was at the care plan meeting she had specifically requested the facility come up with some kind of behavior tracking so the information could be provided to the neuropsychologist.</p> <p>During an interview on 2/16/22 at 11:28 a.m., staff member B said the facility staff were trying to track and document resident #4's behaviors to see what triggers her behaviors. Staff member B said the facility was working on education and plans were developed last week for resident #4, although the resident had admitted to the facility in early 2021.</p> <p>During an interview on 2/16/22 at 2:12 p.m., staff member S said she would dump towels on the table for resident #4 to fold or she would call the activity staff to have someone take resident #4 to the activity room. Staff member S said there were some things she had shared with other staff to help intervene with resident #4's behaviors. Staff member S stated, We've just recently started documenting on resident #4's behaviors. Resident #4 wanders, and she goes into other resident rooms frequently . but they get upset with her coming in their rooms. Especially at 2 or 3 o'clock in the morning. Staff member S said resident #4 would be up for 36 to 48 hours at a time and then crash for a day. She needed constant supervision.</p> <p>During an interview on 2/16/22 at 3:26 p.m., staff member I said she was not the person responsible for writing dementia and behavior care plans for the residents. She said the nursing staff wrote the majority of the care plans for each resident.</p> <p>Review of resident #4's Minimum Data Sets (MDS) from 2/25/21 to 2/2/22 showed the resident had wandered 4-6 days of the look back periods, behavior placed the resident at risk of getting into a potentially dangerous place and had a significant potential to affect other residents by intruding on their privacy.</p> <p>A review of resident #4's Behavioral Symptoms CAA, with an ARD of 8/2/21, showed the resident's wandering behavior had worsened since the last assessment. The seriousness of the resident's behavioral symptoms indicated she was an immediate threat to herself.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of resident #4's current comprehensive care plan showed:</p> <p>a. - Focus: anxiety: I have had medication changes, I are [sic] to revisit on [DATE]rd. The medication change [sic] helped maybe a couple of days. since then I am very restless, my behavior os [sic] becoming demanding, I am wandering all over, I am bumping into others. I am asking excessively for diet coke. nursing to keep in touch with my providers - Date Initiated: 12/15/2021 The Focus failed to include contributing factors or outcomes based on the resident's diagnoses, that were measurable.</p> <p>- Goal: I will remain safe throughout my stay at [Facility name] with the assistance of the staff. The goal failed to include a goal or information on how the resident may not negatively affect others, or how the resident's quality of life may be improved.</p> <p>- Interventions: I need constant supervision when I am out of bed. I wander through the facility, and into others rooms. I ask for things nonstop, please monitor that I do not overeat, or drink too much at one time. toilet me often. Please have patience, as I just do not understand, I cannot sit still when IO [sic] am up. I do get very upset and can [sic] verbally abusive to others - Date Initiated: 12/15/2021. The interventions failed to correlate to outcomes, and did not address how staff were to protect other residents.</p> <p>b. - Focus: MOOD/DEPRESSION- My PHQ severity score was 7/27. Depression causal factors include Diagnosis and history of depression; Reaction to multiple losses and increased dependency; Anger management and emotional distress. I presented with symptoms of depression during the PHQ interview including being so fidgety or restless that I have been moving around a lot; Feeling down, depressed, or hopeless; Feeling tired, or having little energy.</p> <p>Date Initiated: 02/08/2022</p>

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NAME OF PROVIDER OR SUPPLIER Bella Terra of Billings		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 24th St W Billings, MT 59102	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40068</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision to 1 (#56) of 2 sampled residents, who were at risk for aspiration during meals; failed to prevent and remove a hazard for 1 (#12) of 15 sampled residents, and the electrical box located next to the resident's bed and recliner was pulled away from the wall and the wires could be observed; and the facility staff failed to secure chair railing in a resident's room, for 1 (#163) of 13 sampled residents. Findings include:</p> <p>1. During an observation on 2/15/22 at 9:18 a.m., resident #56 was seated in her wheelchair, eating breakfast in her room, and coughing while she was eating her French toast. She was not being supervised by staff during the meal.</p> <p>During an observation on 2/16/22 at 8:50 a.m., resident #56 was seated in her wheelchair, in her room eating breakfast. She was not being supervised by staff during the meal.</p> <p>During an interview on 2/16/22 at 9:00 a.m., staff member J stated, if a resident needed assistance with meals the resident would be seated in the dining room. None of the residents that were eating in their room needed to be supervised while eating. Staff member J stated when the facility was not in outbreak (of Covid 19) it was a lot easier to make sure residents were being supervised when eating because staff could watch them all at once in the dining room. Staff member J stated resident #56 was not being supervised while eating, and she did not need supervision while eating.</p> <p>Review of resident #56's Speech Therapy Evaluation, dated 9/28/21, showed, .New Goal ST will educate nursing staff on Pt [patient] compensatory strategies to reduce risk of aspiration for least restrictive diet. Target date: 10/21/21 .ST educated CNA on Pt needing supervision for meals .</p> <p>Review of resident #56's care plan, with an initiation date of 4/26/21 showed, .Serve meals in dining room with supervision .</p> <p>44770</p> <p>2. During an observation and interview on 2/14/22 at 3:56 p.m., resident #12 stated his electrical plug was falling off the wall. The electrical box located next to his bed and recliner was pulled away from the wall and the wires could be observed through the gap between the outlet and the wall.</p> <p>During an interview on 2/15/22 at 2:40 p.m., staff member A stated, There is no request for the electrical outlet coming off the wall (in resident #12's room), so we made one today.</p> <p>A record review of a work order for the maintenance request, dated 2/15/22, showed a request to fix the electrical outlet after surveyors pointed out that the electrical box was coming away from the wall.</p> <p>45448</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. During an observation, interview, and record review, on 2/15/22 at 8:35 a.m., a surveyor observed a chair rail that was falling off of the wall in the resident's room. Resident #163 said the railing had been in that condition since she was admitted . Record review showed she was admitted on [DATE].</p> <p>During an interview on 2/16/22 at 4:45 p.m., staff member A was not aware of the broken chair rail in resident #163's room. Staff member A was not able to find a maintenance work order request for repair of the chair rail.</p> <p>A review of facility document, Work Order #3999, dated 2/16/22, showed staff member A placed a request for the chair rail repair for resident #163's room.</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>45447</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate nutritional interventions were provided and monitored for 1 (#51) of 2 sampled residents. This deficient practice contributed to the resident having an unplanned severe weight loss of 23.4% in under 3 months. Findings include:</p> <p>During an observation and interview, on 2/15/22 at 9:15 a.m., resident #51 received his breakfast which consisted of two eggs, one cup of yogurt, and a cup of orange juice. Resident #51 stated he did not get the 2 oz of ham he requested, and this was not the first time it had happened. The resident stated missing food items occurred about six out of ten meals. Review of the resident's food selection card on the resident's food tray showed the resident requested 2 oz of ham, in addition to two eggs, yogurt, and orange juice.</p> <p>During an interview on 2/16/22 at 8:29 a.m., staff member O stated the facility's system for nutrition monitoring was broken. Staff member O stated her vitamin recommendations, in addition to meat and other proteins, were needed to improve resident #51's wound healing. Staff member O stated the staff were not recording food intake every day. Staff member O stated the facility was supposed to have meetings to discuss residents who had severe weight loss, but the meetings did not happen.</p> <p>During an interview on 2/16/22 at 9:43 a.m., staff member N stated residents' food intake amounts were supposed to be documented every shift by the CNAs, and the CNAs were to let the nurses know if there was an amount eaten that was out of the normal range for the resident. Staff member N stated the food intake amounts were not completed if there were not enough staff, and documentation of food intake had been an issue for the past four months, which caused the lack of consistent food intake documentation for resident #51. Staff member N stated the facility's dietician often asked why meal intakes were not charted because it was important for her to do her job and assess the resident's needs.</p> <p>Review of resident #51's Care Plan, dated 10/24/21, reflected:</p> <p>Focus</p> <p>[Resident #51] is at risk for alteration in nutritional status related to: .wound areas.</p> <p>Goal</p> <p>No significant weight changes x 90 days.</p> <p>Date Initiated: 10/24/2021 .</p> <p>Review of resident #51's SBAR to a provider, dated 12/7/21, reflected, Background: .He has lost 5 lbs in the last couple weeks.Physician Orders: Will eval[uate].</p> <p>Review of resident #51's Nutrition Progress Note, dated 1/10/21, reflected:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Recommend:</p> <ol style="list-style-type: none"> 1. CMP. 2. Multivitamins with minerals one po daily with breakfast. 3. 500 mg of vitamin C one po TID with meals for skin healing. 4. 220 mg of zinc sulfate one po daily x 10 days for skin healing. 5. Weekly weights . <p>MD and DON were notified of the nutrition recommendations in writing.</p> <p>Review of resident #51's Nutrition Progress Note, dated 2/4/22, reflected:</p> <p>.Significant wt. [weight] loss x 3 mo [months] (23.4%/39.3# [pounds]). No labs are available to review . Nutrition recommendations from 1/10/22 were not accepted. To prevent further wt. loss and to heal the skin, the resident needs the following:</p> <ol style="list-style-type: none"> 1. Glucerna one po BID between meals. 2. Multivitamins with minerals one po daily with breakfast. 3. 500 mg of vitamin C one po TID with meals for skin healing. 4. 220 mg of zinc sulfate one po daily x 10 days for skin healing. <p>MD and the DON were notified of the above in writing.</p> <p>Review of resident #51's Order Details, dated 2/11/22, reflected, Glucerna one time a day for Wound Healing. Order Date: 2/11/2022.</p> <p>This order was started seven days after the staff member O's recommendations, and was not at the frequency staff member O recommended to prevent further weight loss.</p> <p>Review of resident #51's NUTRITION - Amount Eaten report, dated 12/1/21-2/15/22, reflected amounts of meals eaten were not documented for 45.3% of the days (34 out of 75 days).</p> <p>A review of the facility's policy, Intake and Output and Fluid Restriction, created March 2021, reflected:</p> <p>To maintain a relative balance intake and output is essential for well-being and life. Accurately recording intake and output will assist in the assessment of this balance .</p> <ol style="list-style-type: none"> 5. Record the total intake and output at the end of each shift. 		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>45447</p> <p>Based on observation, interview, and record review, the facility failed to implement pain interventions in line with the resident's goals for 1 (#38) of 1 sampled resident. This deficient practice had the potential to affect the resident's ADLs and quality of life. Findings include:</p> <p>During an interview on 2/15/22 at 8:28 a.m., resident #38 stated his pain was not managed well, and he could not increase the use of his narcotics due to an interaction with his heart medications. Resident #38 stated he tried to distract himself from the pain, but it did not always work.</p> <p>During an observation and interview on 2/16/22 at 3:28 p.m., staff member Q stated she knew there were as needed (PRN) medications to manage resident #38's pain, and she thought there were distraction methods in his care plan. Staff member Q stated she did not know exactly what was on resident #38's care plan, as she had only worked with him for the past four days. Staff member Q looked at resident #38's care plan in the EMR, and scrolled through the interventions. Staff member Q stated she did not see any non-pharmacological interventions in resident #38's care plan.</p> <p>Review of resident #38's Care Plan, reviewed 1/10/22, reflected:</p> <p>Focus</p> <p>PAIN: I have chronic pain .</p> <p>Goal</p> <p>I wish to be within a pain range that I can tolerate which is less than 5 through the next review.</p> <p>Date Initiated: 12/07/2018</p> <p>Target Date: 01/25/2022.</p> <p>Review of resident #38's Pain Scale Graph, dated 12/1/21 - 2/16/22, reflected the resident's pain level at a five or above during 36.7% (44 of 120 opportunities) for pain assessments.</p> <p>Review of resident #38's Quarterly MDS, with an ARD of 1/14/22, showed the resident had limited his day-to-day activities because of pain over the past five days preceding the MDS assessment.</p> <p>Review of resident #38's January 2022 - February 2022 TAR, MAR, and Care Plan, reflected a lack of non-pharmacological pain interventions.</p> <p>A review of the facility's policy, Care Planning, created September 2019, reflected:</p> <p>Policy:</p> <p>Individual, resident-centered care planning will be maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life .</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Each resident has the right to .continue their life-patterns as able .</p> <p>Procedure: .</p> <p>6.It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes.</p> <p>8. Care plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur.</p> <p>Resident 38's EHR documentation showed the resident's pain rating was above the scale noted on the care plan goal, on a consistent basis, and the resident's daily activities were hindered, but the facility failed to identify and implement alternate nonmedicinal interventions for the residents comfort and pain management needs.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>40068</p> <p>Based on interview and record review, the facility failed to shower residents timely, due to short staffing, to promote cleanliness and comfort for 5 (#s 9, 13, 24, 56, and 60) of 15 sampled residents; and failed to: provide enough staff to assist residents with their needs in a timely manner, chart daily food intake, assist with incontinence care as needed, assist with resident transfers safely, and order needed supplies for the resident, for 6 (#s 3, 4, 5, 27, 51, and 57) of 15 sampled residents. Findings include:</p> <p>During an interview on 2/16/22 at 9:30 a.m., staff member L stated she used to help with bathing residents in November and December of 2021, as well as January of 2022. Staff member L stated up until recently, the facility did not have a bath aide. Staff member L stated during that time, the facility was very short staffed, and bathing was not getting done if there were other CNA tasks. Staff member L stated there were quite a few days when residents were not getting bathed due to not having staff.</p> <p>1. Review of resident #24's bathing documentation showed the resident did not receive a shower from:</p> <p>11/4/21 - 11/22/21 (18 days)</p> <p>12/16/21 - 12/30/21 (14 days)</p> <p>2. Review of resident #56's bathing documentation showed the resident did not receive a shower from:</p> <p>12/9/21 - 12/30/21 (21 days)</p> <p>During an interview on 2/16/22 at 8:43 a.m., staff member K stated if the shower sheet said 'non-applicable,' that meant the shower did not get done. Staff member K stated, Back in December 2021 showers were not getting done, we were busy doing CNA duties, and we did not have a bath aide.</p> <p>45447</p> <p>3. During an interview on 2/14/22 at 4:10 p.m., resident #3 stated he had to wait a while, sometimes hours, when he rang the bell for assistance because the facility was shorthanded with staff, especially on the weekends.</p> <p>4. During an interview on 2/14/22 at 4:31 p.m., resident #27 stated the facility had light staffing on weekends, he had to wait a while when he needed assistance. Resident #27 stated it was dangerous that the facility was short staffed, because people could fall.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. During an interview on 2/16/22 at 8:29 a.m., staff member O stated the nursing staff were not charting daily intakes and outputs of food and fluid because the facility was short staffed. Staff member O stated it was difficult to determine what resident #51 needed nutritionally when she could not tell what he had been eating.</p> <p>6. During an interview on 2/16/22 at 9:43 a.m., staff member N stated it was typical for one nurse to oversee 20 residents, and there had been several nights where one nurse oversaw 47 residents. Staff member N stated one of those nights was on 2/14/22, where she worked midnight to 6:00 a.m., otherwise the nurse that night would have had 47 residents to oversee. Staff member N stated weekend staffing had been short since November (2021). Staff member N stated because of the short staffing, the staff would perform a one person assist when a resident required a two person assist with a lift, and this was dangerous because a resident could fall. Staff member N stated she had told her managers about the staffing concern, but it seemed like no one had done anything to remedy it, and she did not see anyone from management help on the floor. Staff member N stated that staff were leaving, and the agency staff hardly showed up for work. Staff member N stated resident brief changes were not getting done due to short staffing, and because of this, resident #5 and 57's incontinence briefs were not changed during the night shift on 2/15/22.</p> <p>During an interview on 2/16/22 at 9:59 a.m., staff member N stated that on 2/12/22, the unit ran out of catheter bags, gloves, and insulin syringes. Staff member N stated that staff member P oversaw supply ordering, but was doing three other jobs: reception, staff coordinator, and scheduling, because the facility was short staffed, and she had been unable to keep up with the supply needs of the facility. Staff member N also stated because of short staffing, the residents received breakfast late, at 8:30 a.m., on 2/12/22.</p> <p>45448</p> <p>7. During an interview on 2/15/22 at 1:17 p.m., resident #13 said, In January, I didn't have a shower for 2 weeks. They didn't have staffing to provide a shower.</p> <p>A record review of a facility document for bathing tasks, dated 1/17/22 through 1/26/22, showed resident #13 preferred to shower twice weekly. Resident #13 received a shower on 1/17/22 and 1/26/22, nine days apart. A record of resident #13's bathing task documentation for 1/1/22 through 1/16/22 was not provided prior to the end of the survey.</p> <p>8. During an interview on 2/15/22 at 8:15 a.m., resident #60 stated, night shift was often short staff, and she had gone seven to nine days without a shower. Resident #60 said she had talked and sent notes to staff member A about showering.</p> <p>A record review of a facility document for bathing tasks, dated 1/17/22 through 1/31/22, reflected, resident #60 received a shower on 1/17/22 and 1/30/22, with 18 days between showers. A record of resident #60's bathing task documentation for 1/1/22 through 1/16/22 was not provided prior to the end of the survey.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>9. During an interview on 2/15/22 at 10:45 a.m., resident #9 stated, last month she went without showers. Resident #9 said she needed to have her pannus cleaned daily and the facility had run out of wipes. Resident #9 said, when that happened, she could smell herself and hated it. Resident #9 also stated, staffing was difficult, staff called in or did not show up, the facility would have to find someone emergently. The CNA would come to the call light to assist and tell resident #9 that they would be back after assisting others or finding help and turned the call light off. The CNA would forget or get busy, and not return, so resident #9 had to turn her call light back on.</p> <p>A record review of facility document for bathing tasks, dated 1/17/22 through 1/31/22, reflected, resident #9 preferred bathing two times a week. Resident #9 received only one shower between 1/17/22 and 1/31/22.</p> <p>During an interview on 2/16/22 at 7:43 a.m., staff member S stated, When I need help with a Hoyer lift, I need to find someone to help, and I can't always find someone. I have let scheduling know we need help due to resident #4. I don't have time to take proper care of the residents. Staff member S said she spent five hours one day just attending to resident #4, to keep her from running into walls and to keep her safe. Staff member S said the unit had ten residents, with five residents requiring a two person assist. Currently the Copper Crest [NAME] Unit was staffed with one CNA for the ten residents, resident #4 resides on this unit.</p> <p>During an interview on 2/16/22 at 11:28 a.m., staff member B stated the Copper Crest [NAME] and Rim View [NAME] were considered all one unit. The facility staffing standard was four CNAs and two bath aides. When staff called off, the facility attempted to get the shift covered with prn and on call staff. One staff member carried an on-call phone. Sometimes, it would require a manager to cover the shift.</p> <p>A record review of the Facility Assessment, dated December 2021- November 2022, reflected:</p> <p>. Our staffing plan is exclusively based on keeping the continued needs of our resident in focus and providing adequate staffing levels at all times so that their basic, individualized needs are met.</p> <p>Nursing services . Staffing levels appointed given the unique needs of the residents and the units they reside on.</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient and competent staff were available for 1 (#4), based on the residents comprehensive assessments, for a resident with dementia/Alzheimers, and the resident's behavior hindered her daily life and that of others, to include 2 (#9 and 16) of 4 sampled residents. Staff working with resident #4 lacked the necessary training on the resident's individual needs, and ways to assist or effectively intervene with resident #4's behaviors/activity. Findings include:</p> <p>Resident #4 was admitted to the facility with Alzheimer's and vascular dementia with behavioral disturbance and conduct disorder. The resident had been at the facility since February 2021.</p> <p>During an interview on 2/14/22 at 3:53 p.m., resident #16 voiced concerns about resident #4's behaviors. Resident #16 said the nursing staff spent a lot of time chasing resident #4 around the facility, and taking care of resident #4 was at the expense of caring for the rest of the residents in the facility. Resident #16 said resident #4 wandered all around, and would yell for help. The resident went into everyone's room at all times of the day and night, and resident #16 said that caused a huge lack of privacy. Resident #16 said she had filed a grievance report with the facility due to resident #4's wandering, and entering resident rooms. Resident #16 said there had been a number of times the medication pass had been interrupted because the nurse and the CNA were trying to corral resident #4. Resident #16 said resident #4 also wandered the unit and yelled all night, and no one else got any sleep. Resident #16 said the unit did not have enough staff to take care of resident #4, and the rest of the residents on the unit.</p> <p>During an observation on 2/15/22 at 9:37 a.m., resident #4 was going down the hall calling hello. The resident rolled into a wall calling out Hello, I am here. I am coming in. Hello, hello, hello. A staff member came out of room [ROOM NUMBER], saw resident #4 and wheeled her back to her room.</p> <p>During an interview on 2/15/22 at 10:45 a.m., resident #9 said staff spent a lot of time chasing resident #4, and trying to keep her out of other resident rooms. Resident #9 said resident #4 always entered her room at night when she was sleeping and woke her up. Resident #9 said she did not sleep well.</p> <p>During an interview on 2/16/22 at 9:11 a.m., NF2 said the facility did not provide adequate care for resident #4, and I know she wanders and goes into other resident rooms, and they get upset. NF2 said the facility had a recent care plan meeting for resident #4, and all disciplines were supposed to attend. NF2 said, It was me, the activity director, social services, and the ombudsman. NF2 said nursing should have been in attendance since resident #4's behaviors were all related to her medical problems.</p> <p>During an interview on 2/16/22 at 11:28 a.m., staff member B said if resident #4 was having a difficult day the facility would have a plan to provide someone to come in to help if she was overwhelming the staff. Although the facility stated this plan was in place, the resident's behaviors continued to negatively affect others.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bella Terra of Billings		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 24th St W Billings, MT 59102	
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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/16/22 at 2:12 p.m., staff member S said she had not received any behavioral or dementia training for resident #4. Resident #4 wanders, and she goes into other resident rooms frequently. The other residents understand she can't see, and she has dementia, but they get upset with her coming in their rooms. Especially at 2 or 3 o'clock in the morning. She said the other residents on Copper Crest [NAME] would get upset because when resident #4 is on the go, she needed constant supervision, and the other residents did not get their needs addressed.</p> <p>During an interview on 2/16/22 at 2:18 p.m., staff member FF said she had not received any education or training on minimizing or limiting resident #4's behaviors.</p> <p>During an interview on 2/16/22 at 3:26 p.m., staff member I said she had not provided actual training to facility staff in regards to resident #4's diagnoses and behaviors.</p> <p>Review of the facility's Grievance and Satisfaction Form, dated 2/7/22, showed resident #16 had filed a grievance with the facility regarding resident #4's behaviors. Resident #16 felt it necessary to file a grievance related to the concerns and #4 intruding on her personal space. Resident #4's staff supervision was not adequate to meet either resident #4's or #16's needs.</p> <p>Review of resident #4's nursing progress notes showed:</p> <ul style="list-style-type: none"> - 1/27/22 at 9:47 p.m.: . Goes into other resident's [sic] rooms . runs into staff and walls with wheelchair, constant yelling and screaming, and wanders the halls . No nonpharmacological or pharmacological interventions were documented at that time. - 2/4/22 at 12:27 a.m.: . Enters other resident's [sic] rooms . constantly yelling. Is very difficult to redirect . No nonpharmacological or pharmacological interventions were documented at that time. - 2/14/22 at 6:14 a.m.: Late note for 2/13/22, resident slept on and off throughout the morning. Up late afternoon with calling out help me, help me. Resident had snacks and a diet soda. She wandered around trying to get into other resident's room. No nonpharmacological or pharmacological interventions were documented. - 2/14/22 at 7:19 p.m.: Resident continuously wondering [sic] while she is awake. wanders into others rooms. constantly wanting someone by her side to talk to. - 2/13/22 evening staff documented the resident was wandering and yelling all night. - 2/14/22 day staff documented the resident was voicing repetitive statements, and wandering. <p>Review of resident #4's Minimum Data Sets (MDS) from 2/25/21 to 2/2/22 showed the following:</p> <ul style="list-style-type: none"> - Significant MDS, with an ARD of 8/2/21, showed resident #4 had wandered 4-6 days of the seven day look back period. The impact of the wandering behavior showed the behavior had a significant potential to affect other residents by intruding on their privacy. <p>A review of resident #4's care plan showed:</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Interventions: I need constant supervision when I am out of bed. I wander through the facility, and in to others rooms . I do get very upset and can [sic] verbally abusive to others</p> <p>Date Initiated: 12/15/2021</p>

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<p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997</p> <p>Based on observation, interview, and record review, the facility failed to ensure necessary services were provided for a resident who displayed behavioral outbursts, wandering, intruding on others, and calling out, and the resident had a diagnosis of Alzheimer's/dementia, for 1 (#4); and resident #4's behavior affected other residents, to include 2 (#s 9 and 16) of 4 sampled residents. The facility also failed to use available medication to treat and attempt to decrease resident #4's agitation/behavior if there was no improvement shown after an antipsychotic medication was started. Resident #4's care plan lacked non-pharmacological interventions for the resident's behavioral needs. These failures continued over an extended period of time, without timely action taken to address the concerns, which affected the residents quality of life on a regular basis. Findings include:</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnoses including: mixed Alzheimer's and vascular dementia with behavioral disturbance, Anton's syndrome, anxiety, major depression, and conduct disorder.</p> <p>During an interview on 2/14/22 at 3:53 p.m., Resident #16 said resident #4 wandered all around and would yell for help. The resident went into everyone's room at all times of the day and night, and resident #16 said that caused a huge lack of privacy. Resident #16 said she had filed a grievance report with the facility due to resident #4's wandering, and entering resident rooms.</p> <p>During an observation on 2/15/22 at 9:37 a.m., resident #4 was going down the hall calling hello. The resident rolled into a wall calling out Hello, I am here. I am coming in. Hello, hello, hello. A staff member came out of room [ROOM NUMBER], saw resident #4 and wheeled her back to her room.</p> <p>During an interview on 2/15/22 at 10:45 a.m., resident #9 said resident #4 always entered her room at night when she was sleeping and woke her up. Resident #9 said she did not sleep well.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/16/22 at 9:11 a.m., NF2 said the facility did not provide adequate care for resident #4. NF2 said the resident had a diagnosis of Anton's syndrome - which was cortical blindness. She said resident #4 would confabulate, which was part of the syndrome, and convince people she could see. The expectations of the facility staff were for resident #4 to be able to do the same things as a sighted person. NF2 said resident #4 had seen a neuropsychologist several times in the last couple of months. NF2 said the neuropsychologist told her that resident #4's short-term memory was to the point where it reset every 3-5 minutes. [Resident #4] can be combative, but if you let her know you are there and will be touching her she is calm. If you just walk up to her and she doesn't know you are there, it scares her and she will become combative. NF2 said given the limitations imposed by resident #4's short term memory problems, she felt resident #4 viewed the facility as her home, and therefore could not understand why she could not go into any room she chose, and when in those rooms perhaps she saw the other residents as intruders. NF2 said the facility had a recent care plan meeting for resident #4, and all disciplines were supposed to attend. NF2 said, It was me, the activity director, social services, and the ombudsman. NF2 said nursing should have been in attendance since resident #4's behaviors were all related to her medical problems. NF2 said she knew the facility did not want resident #4 in the facility due to all the behavior problems, but nursing would not document her behaviors consistently, good and bad, so the neuropsychologist could make a determination on the approaches and medications for the resident to improve her quality of life. NF2 said when she was at the care plan meeting she had specifically requested the facility come up with some kind of behavior tracking so the information could be provided to the neuropsychologist.</p> <p>During an interview on 2/16/22 at 11:28 a.m., staff member B said the facility staff were trying to track and document resident #4's behaviors to see what triggers her behaviors. She said staff member I was involved with this. Staff member B said the facility was working on education and plans were developed last week for resident #4, although the resident had admitted to the facility in early 2021.</p> <p>Review of a social service progress note, dated 2/11/22 at 2:48 p.m., showed: A quarterly care conference was held today, 2/11/22 @ 10:30 a.m. The following were present: daughter, Ombudsman, Activities, and Social Services. SS went through information that was on Multidisciplinary Care Conference UDA. Daughter had some concerns. SS spoke to Administrator and DON about those concerns. DON put behavior charting in MAR so that the nurses would have to progress note each shift and mark it off that it was done. Code status reviewed.Appointment scheduled next Thursday, 2/17/22 @ 1pm with [neuropsychologist's name]. SS will send updated progress notes early next week. SS will send a referral to [Hospital name] in [NAME]. SS will continue to follow resident.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/16/22 at 2:12 p.m., staff member S said she had not received any behavioral or dementia training for resident #4. The staff member said the social worker was going to provide training specific to resident #4's behavioral concerns, but it never happened. She said she would dump towels on the table for resident #4 to fold or she would call the activity staff to have someone take resident #4 to the activity room. Staff member S said there were some things she had shared with other staff to help intervene with resident #4's behaviors. Staff member S stated, We've just recently started documenting on resident #4's behaviors. Resident #4 wanders, and she goes into other resident rooms frequently. The other residents understand she can't see, and she has dementia, but they get upset with her coming in their rooms. Especially at 2 or 3 o'clock in the morning. Staff member S said resident #4 would be up for 36 to 48 hours at a time and then crash for a day. She said the other residents on Copper Crest [NAME] would get upset because when resident #4 is on the go, she needed constant supervision, and the other residents did not get their needs addressed. Staff member S stated, On this unit it's me . and the nurse to provide care for the residents.</p> <p>During an interview on 2/16/22 at 2:18 p.m., staff member FF said she had not received any education or training on minimizing or limiting resident #4's behaviors.</p> <p>Review of resident #4's neuropsychologist's report, dated 12/28/2021, showed, Plan: . - start risperidone 0.5mg BID, after 2 days if no improvement in behavior increase to 1mg BID .</p> <p>During an interview on 2/16/22 at 3:16 p.m., staff member B said she was not aware the neuropsychologist had written, If no improvement in behaviors increase risperdone to 1 mg BID.</p> <p>During an interview on 2/16/22 at 3:26 p.m., staff member I said she had not provided actual training to facility staff in regards to resident #4's diagnoses and behaviors. Staff member I said the DON told her last week she needed to do a huddle with the nursing staff for resident #4's diagnosis and behavior management. Staff member I said she was not the person responsible for writing dementia and behavior care plans for the residents. She said the nursing staff wrote the majority of the care plans for each resident.</p> <p>Review of the facility's Grievance and Satisfaction Form, dated 2/7/22, showed resident #16 had filed a grievance with the facility regarding resident #4's behaviors. Resident #16 wrote, [resident name] was being loud and disruptive all night 2/5 claiming there was fire. Approx. 5am 2/6 [resident name] opened my door and walked in while I was partially naked during check & change. [Staff name] removed her but my privacy was violated & I wanted it on the rec. The facility's resolution for this grievance showed, 1. Resident evaluated by physician. 2. Stop sign placed on door. The facility's investigation for this grievance showed, Residents upset c [with] other resident A [resident #4]. Resident A wanders & is blind. Resident A wandered into resident B room. Attempted re-direction unsuccessful [sic].</p> <p>Review of resident #4's nursing progress notes showed:</p> <p>- 1/27/22 at 9:47 p.m.: Continues to have adverse behaviors. Goes into other resident's [sic] rooms, continuously asks to go to the restroom when she has just been, asks to lay down and gets right back up, runs into staff and walls with wheelchair, constant yelling and screaming, and wanders the halls . Has not slept thus far this shift. will continue to monitor. No nonpharmacological or pharmacological interventions were documented at that time.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- 2/4/22 at 12:27 a.m.: Resident continues with behaviors. Enters other resident's [sic] rooms, runs into staff with wheelchair, goes to bed and gets right back up, runs into walls ad [sic] equipment, and constantly yelling. Is very difficult to redirect. Denies any pain at this time. Will continue [sic] to monitor. No nonpharmacological or pharmacological interventions were documented at that time.</p> <p>- 2/9/22 at 10:26 p.m.: Resident was running chest into the table in the dinning [sic] room on the west unit. Non-Pharmacological Interventions: Redirected, resident stated that she did not know she was doing it.</p> <p>- 2/14/22 at 6:14 a.m.: Late note for 2/13/22, resident slept on and off throughout the morning. Up late afternoon with calling out help me, help me. The resident had snacks and a diet soda. She wandered around trying to get into other residents' rooms. Had to one on one to keep her from bothering others. No nonpharmacological or pharmacological interventions were documented.</p> <p>- 2/14/22 at 7:19 p.m.: Resident continuously wondering [sic] while she is awake. wanders into other rooms. constantly wanting someone by her side to talk to.</p> <p>A review of resident #4's monitoring record, dated 2/1/2022 to 2/28/2022 with a start date of 2/11/2022, showed, Nurse must enter progress note every shift regarding residents [sic] behavior. Identify wandering into rooms, yelling out, repetitive statements, or others, every shift for Behavior</p> <p>- 2/11/22 evening staff documented the resident was voicing repetitive statements and wandering.</p> <p>- 2/12/22 day staff documented the resident was voicing repetitive statements and wandering.</p> <p>- 2/12/22 evening staff failed to document the resident was exhibiting any behaviors.</p> <p>- 2/13/22 day staff documented the resident was wandering.</p> <p>- 2/13/22 evening staff documented the resident was voicing repetitive statements, wandering, and yelling all night.</p> <p>- 2/14/22 day staff documented the resident was voicing repetitive statements, and wandering.</p> <p>- 2/14/22 evening staff documented NA for repetitive statements, wandering, and yelling.</p> <p>Review of resident #4's Minimum Data Sets (MDS) from 2/25/21 to 2/2/22 showed the following:</p> <p>- Significant Change MDS, with an ARD of 8/2/21, showed resident #4 had wandered 4-6 days of the seven-day look-back period. The impact of the wandering behavior showed the behavior placed the resident at risk of getting into a potentially dangerous place and had a significant potential to affect other residents by intruding on their privacy.</p> <p>- The Quarterly MDS, with an ARD of 11/2/21, showed resident #4 had wandered daily during the 7-day look-back period. The impact of the wandering behavior to the resident and other residents was not completed.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- The Quarterly MDS, with an ARD of 2/2/22, showed resident #4 had a severe cognitive deficit. The resident had wandered 4-6 days of the 7-day look-back period. The impact of the wandering behavior of the resident and other residents was not completed.</p> <p>A review of resident #4's Behavioral Symptoms CAA, with an ARD of 8/2/21, showed the resident was wandering 4-6 days of a 7-day look-back period, and the resident's wandering behavior had worsened since the last assessment. The seriousness of the resident's behavioral symptoms indicated she was an immediate threat to herself.</p> <p>A review of resident #4's current care plan showed:</p> <p>a. - Focus: anxiety: I have had medication changes, I am [sic] to revisit on [DATE]rd. The medication change [sic] helped maybe a couple of days. since then I am very restless, my behavior os [sic] becoming demanding, I am wandering all over, I am bumping into others. I am asking excessively for diet coke. nursing to keep in touch with my providers</p> <p>Date Initiated: 12/15/2021</p> <p>- Goal: I will remain safe throughout my stay at [Facilty name] with the assistance of the staff.</p> <p>Date Initiated: 12/15/2021</p> <p>Target Date: 03/31/2022</p> <p>- Interventions: I need constant supervision when I am out of bed. I wander through the facility, and into others rooms. I ask for things nonstop, please monitor that I do not overeat, or drink too much at one time. toilet me often. Please have patience, as I just do not understand, I cannot sit still when IO [sic] am up. I do get very upset and can [sic] verbally abusive to others</p> <p>Date Initiated: 12/15/2021</p> <p>b. - Focus: MOOD/DEPRESSION- My PHQ severity score was 7/27. Depression causal factors include Diagnosis and history of depression; Reaction to multiple losses and increased dependency; Anger management and emotional distress. I presented with symptoms of depression during the PHQ interview including being so fidgety or restless that I have been moving around a lot; Feeling down, depressed, or hopeless; Feeling tired, or having little energy.</p> <p>Date Initiated: 02/08/2022</p> <p>- Goal: I will engage in mental health treatment and work on improving mood state and outlook, through my next review date.</p> <p>Date Initiated: 02/08/2022</p> <p>Target Date: 03/31/2022</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- Interventions: I will talk to staff that I feel comfortable with about ideas to moderate and reduce my mood distress symptoms such as: sharing thoughts and feelings that have contributed to depression. Staff will notify my Provider and Social Services if they see an increase in any signs and/or symptoms of depression.</p> <p>Date Initiated: 02/08/2022</p> <p>During an interview on 2/17/22 at 8:03 a.m., staff member D said she did not write care plans. She said the unit managers did that. Staff member D said staff member C wrote the care plans for the unit the resident resided on.</p> <p>During observation and attempted interview on 2/17/22 at 8:06 a.m., staff member C was working at a medication cart. Staff member C verified she would have written the majority of resident #4's care plan. Staff member C was not available for further interviews prior to the survey team exiting the facility.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>32997</p> <p>Based on observation, interview, and record review, the facility failed to ensure an as needed (PRN) psychotropic medication was reviewed after 14 days, and the facility failed to ensure the medication was discontinued unless a rationale for continuing the medication was documented by the physician, for 1 (#4) of 5 sampled residents. Findings include:</p> <p>Review of resident #4's Order Summary Report, active orders as of 2/15/2022, showed the resident was prescribed, on 12/28/2021, risperdone 0.5 mg by mouth every 6 hours as needed for agitation .</p> <p>Review of medication administration records for January 2022 and February 2022 showed resident #4 had a PRN risperdone order effective 12/28/2021. The resident had received doses of the PRN risperdone on 1/10/22, 1/16/22, 1/24/22, 2/4/22, 2/7/22, and 2/11/22, with a total use of six times in 45 days.</p> <p>Review of a pharmacy consultation report, with a recommendation date of 1/19/22, showed the pharmacist recommended the PRN risperdone be discontinued. The consultation report also contained instructions to the physician for continued use of an as needed psychotropic to include: A new order should not be written without the prescriber directly examining the resident and assessing the resident's condition and progress to determine if the PRN antipsychotic is still needed. The physician's response to the pharmacist's consultation report was marked: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: Continue for behaviors if needed. The physician signed off his rationale on 1/26/22.</p> <p>Review of physician progress notes dated 1/27/22 and 2/12/22 failed to show the practitioner reassessed resident #4 for the PRN risperdone on either date.</p> <p>During an interview on 2/16/22 at 10:33 a.m., a nurse said staff member Z was the physician's assistant who took care of the residents at the facility. The nurse said staff member AA only did the certification visits. The nurse said NF1 was also responsible for controlling medications for resident #4.</p> <p>Review of resident #4's psychiatric progress notes dated 12/7/21 and 12/28/21, did not show NF1 had prescribed the PRN risperdone for the resident.</p> <p>During an interview on 2/16/22 at 10:49 a.m., staff member B said she had identified this as a problem, nursing not getting a 14 day time limit for the PRN psychotropic medications from the prescribers. Staff member B said nursing education on this problem had been started last Thursday 2/10/22.</p> <p>Review of facility policy Psychotropic Medications, revised date 5/18/2021, showed:</p> <p>- 6. As needed (PRN) psychotropic medications for psychological symptoms will not be prescribed for great than 14 days. After 14 days, the physician must evaluate the resident for the continued need for the prn psychotropic medication and can rewrite the order .</p>		

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NAME OF PROVIDER OR SUPPLIER Bella Terra of Billings		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 24th St W Billings, MT 59102	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45447</p> <p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to ensure nursing staff input the correct medication orders for 2 (#s 38 and 262) of 2 sampled residents. These deficient practices had the potential to increase the potential of a blood clot and stroke for resident #262, and delay healing for resident #38. Findings include:</p> <p>1. During an interview on 2/16/22 at 10:30 a.m., staff member M stated there was a different process for entering Coumadin orders, compared to other orders, and the Coumadin orders were to be checked by two nurses. One nurse was to input the orders into the EMR, and those orders were to be checked by a second nurse right after they were entered.</p> <p>During an interview on 2/16/22 at 10:33 a.m., staff member B stated the expectation for nursing staff, when entering an order for Coumadin, was to enter the order with an end date, the correct dose from the order, and to enter the order on the facility's Coumadin tracking sheet. Staff member B stated the facility had two nurses assess the order, and there were clinic meetings in the mornings where orders were also reviewed.</p> <p>During an interview on 2/16/22 at 1:37 p.m., staff member B stated the facility was working on creating a policy and system for double checking all medication orders that were entered in the facility's EMR.</p> <p>On 2/16/22 at 2:12 p.m., a request was given to staff member A for the facility's Coumadin order entering policy.</p> <p>During an interview on 2/16/22 at 4:45 p.m., staff member A stated the facility did not have a policy for entering coumadin orders into the EMR.</p> <p>A review of the facility's investigation notes for a facility reported incident, regarding resident #262, submitted 8/13/21, reflected, On 8/12/21 the facility was notified of a significant medication error regarding Coumadin that resulted a critical PT/INR on resident, [#262]. The resident's Coumadin order .was Coumadin 4 mg to be given on 8/7 and 8/8. The nurse working the floor [staff member LL] had entered to [sic] Coumadin order into the EMAR but put the discontinue date as 8/7 resulting in a missed dose on 8/8/21.</p> <p>Review of resident #262's Order Details, dated 8/6/21, reflected, Give 4 mg [Coumadin] by mouth at bedtime every Tue, Sat, Sun for Long term anticoagulant use until 08/07/2021 23:59. The date was circled, and written next to it was, Should have been 8/8/21.</p> <p>Review of the facility's Education/Training sheet, Subject: Coumadin Orders/Process, dated 7/21/21, reflected staff member LL and other staff members received training on the subject, prior to the incident with resident #262, on 8/6/21.</p> <p>A review of the facility's Coumadin checklist reflected there was two spaces for two nurses to verify Coumadin orders, with signatures.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of resident #262's Coumadin checklist reflected one signature by staff member LL, with no other space for a second nurse to verify and sign.</p> <p>2. Review of resident #38's After Visit Summary, dated 1/7/22, reflected:</p> <p>Patient Medication List</p> <p>Cephalexin 500mg capsule .</p> <p>Dose: 1,000 mg .</p> <p>Take 2 capsules (1,000 mg total) by mouth three times a day for 7 days Indications: Skin and Soft Tissue Infection</p> <p>Received morning dose prior to discharge 01/07/2022.</p> <p>Review of resident #38's Order Note, dated 1/13/22 at 12:00 p.m., reflected, Data: Resident was d/c on 1/7/22 and ordered Cephalexin 1000 mg three times daily for seven days. Comments: However, he was only receiving 500 mg three times daily.</p> <p>Review of resident #38's MAR, dated 1/1/22 - 1/31/22, reflected, Cephalexin Tablet 500 MG Give 500 mg by mouth three times a day for infection until 01/14/2022 23:59 -Start Date- 01/08/2022 0600. The MAR reflected this ordered medication regimen was administered from 1/8/22 - 1/14/22. The order for Cephalexin entered was incorrect when compared to the After Visit Summary, and the dose administered was incorrect.</p> <p>A review of the facility's policy, 6.0 General Dose Preparation and Medication Administration, revised 1/1/22, reflected:</p> <p>4. Prior to administration of medication .</p> <p>4.1 Facility staff should:</p> <p>4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose .</p> <p>4.1.2 Confirm that the MAR reflects the most recent medication order .</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>40068</p> <p>Based on interview and record review, the facility failed to provide oversight for a Dietary Manager who was not certified. This deficiency affected 1 (#38) of 1 sampled resident, and any resident consuming food from the kitchen. Findings include:</p> <p>During an interview on 2/14/22 at 3:28 p.m., staff member G stated he was not sure if he was a Certified Dietary Manager.</p> <p>A Dietary Manager certificate was requested, no information was provided by the end of the survey.</p> <p>During an interview on 2/15/22 at 8:28 a.m., resident #38 stated the food at the facility was awful, cold, and there were no options to choose from. Resident #38 stated the cooks in the kitchen did not know how to cook, and the dietary manager did not know what he was doing in the kitchen.</p> <p>During an interview on 2/15/22 at 2:58 p.m., staff member G stated he wasn't sure how the resident allergies were addressed. The dietary staff checked the resident chart for allergies and did not serve the resident that food.</p> <p>During an interview on 2/15/22 at 3:14 p.m., staff member G stated he did not know the cooks needed to take and record the temperatures of cold and hot foods, before they were served to residents, to ensure the food reached/maintained a safe serving temperature. Staff member G stated he had never completed an in-service training with any of the dietary staff members. Staff member G stated they take a training on the computer upon orientation that discusses safe food handling.</p> <p>In-service training documents were requested for dietary staff, to include staff member G, none were provided by the end of the survey.</p> <p>During an interview on 2/16/22 at 3:42 p.m., staff member G stated he was not receiving very much oversight from staff member O. Staff member G stated staff member O had not come into the kitchen to provide training or oversight. He stated he had only talked to her a couple of times on the phone.</p> <p>During an interview on 2/16/22 at 3:42 p.m., staff member G stated he had been changing items on the menu if they do not have the original food item in stock. He stated he was not getting approval by staff member O prior to the change.</p> <p>Review of the Food Temperature Chart, undated, was blank.</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>40068</p> <p>Based on observation, interview, and record review, the facility failed to maintain sufficient dietary staffing to carry out duties in the kitchen. This deficiency affected any resident who consumed food from the kitchen. Findings include:</p> <p>During an observation on 2/14/22 at 3:40 p.m., the kitchen appeared unkept and unclean. There were various food wrappers on the floor. Dried food was in the microwave. The area around the fryer was oily, and dust was visible in the oil. Instant mashed potatoes were sitting out, unwrapped, in a bowl. Various food items in the walk-in cooler were undated and unlabeled. (See F812 for details on cleanliness, food labeling, and storage).</p> <p>During an interview on 2/14/22 at 3:59 p.m., staff member Y stated the kitchen had been very short staffed for a while. She stated that food preparation and cleaning did not get done because of the short staffing. Staff member Y stated the kitchen staff tried to clean as much as they could and tried to remember to label food items.</p> <p>During an interview on 2/15/22 at 8:25 a.m., staff member BB stated he did not know food temperatures needed to be taken before the food was served to the residents. Staff member BB stated, I don't know how to temp the food. I have never done that before. Staff member BB stated he had not had training on how to take and record the temperature of food.</p> <p>During an observation and interview on 2/15/22 at 8:48 a.m., resident #44 was in her room seated beside her bed, with her bedside table in front of her, and she had a clothing protector on. Resident #44 stated, Where is my meal? It's so late.</p> <p>During an interview on 2/16/22 at 3:42 p.m., staff member G stated the mealtimes were at 7:00 a.m. for breakfast, 11:30 a.m. for lunch, and 4:30 p.m. for dinner. He stated the kitchen staff tried to get the food out at that time, however, the kitchen was short staffed. Staff member G stated two additional cooks were in the hiring process. Staff member G stated due to staffing issues in the kitchen the facility had to make a few changes to the foods served to minimize preparation time. Staff member G stated the kitchen had started serving canned vegetables instead of fresh vegetables, and had switched to simpler desserts that did not take as long to make and prepare. Staff member G stated staff member E was from maintenance, but he had been stepping in to cook because the facility did not have enough cooks. Staff member G stated he expected the kitchen staff to clean the kitchen, but he had not provided a cleaning check list for the staff members. Staff member G stated he had been changing items on the menu if they do not have the original food item in stock. He stated he was not getting approval by staff member O prior to the change.</p> <p>Review of the facility's Daily Cleaning Schedule, undated, for the kitchen was blank.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>40068</p> <p>Based on observation, interview, and record review, the facility failed to maintain hot foods at a palatable temperature for 8 (#s 9, 12, 14, 20, 38, 47, 56 and 60) of 15 sampled residents. This deficiency had the potential to affect any resident who consumed food from the kitchen. Findings include:</p> <p>During an interview on 2/15/22 at 8:25 a.m., staff member BB stated he did not know food temperatures needed to be taken before the food was served to the residents. Staff member BB stated, I don't know how to temp the food. I have never done that before. Staff member BB stated he had not had training on how to take and record the temperature of food.</p> <p>During an observation on 2/15/22 at 8:30 a.m., staff member DD took the temperature of resident #20's eggs from his room tray right before he served it to resident #20. The temperature was 91 degrees Fahrenheit.</p> <p>During an observation on 2/15/22 at 8:37 a.m., staff member K took the temperature of resident #9's eggs. The temperature was 90 degrees Fahrenheit.</p> <p>During an interview on 2/15/22 at 8:47 a.m., resident #56 stated the food on her room trays were always cold. She stated she had to get used to eating cold eggs because she did not have a choice.</p> <p>During an interview on 2/15/22 at 3:14 p.m., staff member G stated he did not provide any training to dietary staff on recording or taking food temperatures.</p> <p>A review of the facility's policy, Food Temperatures, dated 2/1/2016, showed:</p> <ol style="list-style-type: none"> .1. Using a food thermometer, obtain final temperatures for all menu items, hot and cold, prior to serving . 2. Temperatures for hot products should be no less than 135 F to keep food out of temperature danger zone. Cold products shall reach temperatures no greater than 41 F. Foods failing to register these temperatures must be reheated/chilled until acceptable temperatures are reached (hot foods minimum 165 for 15 seconds/cold foods <41) 3. Serving temperatures will be recorded by the cook or other designated personnel for all items prior to serving on a temperature log. <p>Review of the Food Temperature Chart, undated, was blank.</p> <p>44770</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/14/22 at 3:56 p.m., NF3 stated resident #12 did not get the food he ordered. Sometimes it was not cooked all the way. He (resident #12) ordered from the alternative menu yesterday and they did not deliver what he ordered from the alternative menu, they only brought what he ordered off the regular menu. Resident #12 stated, The dinners are late, I had to tell them not to give me my dinner insulin until my food comes because sometimes it doesn't come until 8:00 p.m.</p> <p>A review of Resident Council minutes showed:</p> <p>8/10/21- Receiving food they can't eat, or not getting what they requested.</p> <p>9/14/21- Food is still hard and cold. Food is too done or not done enough.</p> <p>11/16/21- Breakfast not arriving before dialysis. Food quality is poor, options for special diets seems non-existent.</p> <p>12/14/21- Food being cold and served late. Mealtimes- receiving lunch at 1-130 and dinner around 7-9ish. Not receiving food on menu or ticket that was ordered.</p> <p>1/13/22- Consistent times of meal, food is better, still have some trouble with tough food.</p> <p>45447</p> <p>During an interview on 2/15/22 at 8:28 a.m., resident #38 stated the food was awful and cold, there were no options, the cooks did not know how to cook, and the dietary manager did not know what he was doing in the kitchen.</p> <p>45448</p> <p>During an interview on 2/14/22 at 3:44 p.m., resident #14 stated the food arrived cold most of the time. Resident #14 had voiced concerns to dietary and to staff member B about the cold food.</p> <p>During an interview on 2/15/22 at 8:15 a.m., resident #60 said the food was always cold and meals were not on time.</p> <p>During an interview on 2/15/22 at 9:01 a.m., resident #47 stated the dinner meal on 2/14/22 was a grilled cheese sandwich with french fries topped with cheese. The sandwich was burnt and the french fries with cheese were a lump of mush. Resident #47 said the meal cart arrived and sometimes it sat for an hour before meal trays were distributed to the residents.</p> <p>During an interview on 2/15/22 at 10:45 a.m., resident #9 stated the food was often cold and late to arrive. Resident #9 said she would be given her medication and got an upset stomach when the meals arrived late. Resident #9 liked to order soup and said her soup often had black flakes floating on top and meals were often burnt.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>45448</p> <p>Based on interview and record review, the facility failed to provide adequate food options to accommodate residents with allergies and intolerances, and failed to consider residents preferences for 2 (#s 16 and 51) of 5 sampled residents. Findings include:</p> <p>1. During an interview on 2/14/22 at 3:53 p.m., resident #16 said, I am allergic to wheat and dairy and that knocks out a lot of the food they (the facility dietary department) serve. The dietary area said they would accommodate it, but that hasn't happened. Resident #16 stated she preferred not to eat a lot of meat, and the facility served a lot of meat.</p> <p>During an interview on 2/15/22 at 2:58 p.m., staff member G stated he wasn't sure how the allergies were addressed. The dietary staff checked the resident chart for allergies and did not serve the resident that food. When asked what the facility had to accommodate resident #16's allergies, staff member G said the facility had coconut milk, frosted flakes, and rice cereal. Staff member G said, I may need to order some gluten free cereals and foods.</p> <p>During an interview on 2/15/22 at 3:25 p.m., resident #16 stated she selected her own meals from the alternate menu. Resident #16 said the selection was very limited and her meals consisted of corn cereal, salad, and lunch meat. Resident #16 provided her own nut butter, and sometimes gluten free bread brought by friends.</p> <p>During an interview on 2/16/22 at 10:17 a.m., staff member O stated, food allergies were not at the top of the facility's list to accommodate. The CNA and kitchen staff would check the resident's diet and if the food was incorrect, will discard the food, and notify the kitchen. Staff member O said the CNAs did not know the different diets and needed training. Staff member O stated, My recommendations are not followed or considered. Wounds, allergies, diabetic or dialysis menus all need work. I am not allowed to go into the kitchen, the staff is new and just doesn't know.</p> <p>A record review of the facility's LGHC Dietary evaluation, dated 9/8/21, by staff member NN, showed, [Resident #16] reports anaphylactic allergies to basil and shellfish with intolerance to wheat and dairy. Resident also avoids multiple foods that produce migraine triggers.</p> <p>A record review of resident #16's diet order listing report, dated 4/15/19, showed an order for a regular diet, regular texture, thin liquids consistency, allergic to shellfish, basil, chocolate, cheddar, strawberries, peanuts, and ranch. Resident #16's allergies included basil, cheddar, chocolate, gluten, milk, peanuts, ranch dressing, shellfish and strawberries. Resident #16 had no beverage preferences identified. Dislikes included: all dairy products, chocolate, cheeses, ham, no wheat cereal, peanuts, pasta, potatoes, ranch dressing, strawberries, and wheat bread.</p> <p>The facility's Selection Sheet, dated 2/15/22, showed resident #16 had a regular diet with double meat portions. Lunch meal options were: mixed vegetables and a choice of beverage. Resident #16's lunch options did not include a meat option.</p> <p>A record review of resident #16's care plan, dated 1/14/22, showed:</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.Honor food preferences per facility ability. Initiated: 3/10/21</p> <p>No wheat bread, no wheat cereal and no milk based dairy products as I have complaints of tight throat, red face and rash when I consume these foods. Initiated 5/15/21 .</p> <p>2. During an observation and interview on 2/15/22 at 9:15 a.m., resident #51 received his breakfast consisting of two eggs, one cup of yogurt, and a cup of orange juice. Resident #51 stated he did not receive the 2 oz of ham he requested, and this was not the first time it had happened. The resident stated missing food items occurred about six out of ten times. Review of the resident's food selection card, on the resident's food tray, showed the resident requested 2 oz of ham, in addition to two eggs, yogurt, and orange juice.</p> <p>Review of resident #51's Care Plan, dated 10/24/21, reflected, Honor food preferences per facility ability providing an alternate menu PRN.</p> <p>A record review of the facility's Alternate Menu choices and Always Available Menu, not dated, showed:</p> <p>Sandwiches: Hamburger or Cheeseburger, Hot Dog, Tuna or Egg Salad, Deli Sandwiches, Bacon, Lettuce and Tomato.</p> <p>Salads: House, Chef, Fruit Plate, Cold Meat and Cheese Plate</p> <p>Sides: Potato Chips, Fruit Cup, Cottage Cheese, Vegetable of the Day, Relish Plate, French Fries</p> <p>Desserts: Pudding, Ice Cream, Dessert of the Meal</p> <p>Soups: Soup of the Day, Chicken Noodle</p> <p>Hot Entrees: Personal Pizza (Cheese, Pepperoni, and Sausage), Corn Dog, Bean Burrito, French Dip w/au jus, Fish Sticks</p> <p>Availability Subject to Change.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40068</p> <p>Based on observation, interview, and record review, the facility failed to label and date food items, as well as maintain a sanitary environment in the kitchen. These deficient practices had the potential to affect any resident consuming food from the kitchen. Findings include:</p> <p>During an observation on 2/14/22 at 3:40 p.m., the following was found in the kitchen:</p> <ul style="list-style-type: none"> - There were white crumbs and various paper garbage items on the floor, and the area under the fryer was greasy with crumbs on the counter. Under the fryer, on the shelf, there were crumbs stuck in grease. - 11 small bowls of a fruit mixture, not covered or dated, were in the refrigerator fridge by the fryer, - 1/2 of a cucumber, and two halves of tomato in saran wrap, were not dated, - A one-gallon bag of hot dogs was left open, and not sealed, - 10 hard boiled eggs with no date and no label, - A small bowl of link sausage, with no date and no label, - A Ziplock bag of minced onions with no date and no label, - 10 eggs in plastic, not sealed, in a metal bowl, without a date, - A small bowl of instant mashed potatoes was on the table next to the fryer with a spoon in it, without a cover, - The microwave had yellow dried food inside, on the plate, and on the sides of the microwave, - 1/2 carrot in a bowl was not sealed or dated; and, - A bag of instant potatoes was located under the fryer, on a shelf, unsealed. <p>Walk in freezer:</p> <ul style="list-style-type: none"> - 3 boxes of food stored on the floor: Brussel sprouts, bread, mac and cheese, and - 3 bags of hot dog buns were on the floor of the freezer. <p>Walk in refrigerator:</p> <ul style="list-style-type: none"> - Egg salad, 5 lb, with no date, <p>(continued on next page)</p>		

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

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> - ricotta cheese, 5 lb, with no date, - red raspberry dessert topping, 7 lb, with no date, - 2 small tortillas, no label, not dated, - 1/2 of a tomato, with no date, - 1 gallon of mayo, without an open date, - 1 gallon of ranch dressing, with no open date, - A sheet pan of what appeared to be bread, without a label or date, - A gallon of milk, without a date; and, - 2 pitchers of a creamy mixture, without a label or date. <p>During an interview on 2/14/22 at 3:59 p.m., staff member Y stated staff were supposed to label and date food items when they put them in the refrigerator. Staff member Y stated items placed in the refrigerator by the fryer were not sealed so it was easy to grab the items quickly. Staff member Y stated the kitchen got cleaned daily, but there was not a sign off sheet to show when the items in the kitchen were cleaned. Staff member Y stated, If its dirty, we clean it.</p> <p>During an interview on 2/14/22 at 4:13 p.m., staff member G stated all items in the refrigerator should have a date of when the item was made or opened. He stated the kitchen had an a.m. and p.m. cleaning schedule, however, there was no sign off sheet to monitor that the items on it were being cleaned.</p> <p>Review of the facility policy titled, Kitchen, revised on August 1st, 2019, showed, .e. Refrigerated food should be covered, dated, labeled, and shelved to allow air circulation .</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>45447</p> <p>Based on interview and record review, the facility failed to implement a consistent antibiotic stewardship program, including infection surveillance. This deficient practice had the potential to negatively affect residents taking antibiotics for infections, and increase the incidence of adverse events associated with infections and antibiotic use throughout the facility. Findings include:</p> <p>During an interview on 2/16/22 at 1:53 p.m., staff member B stated the facility's previous DON had not kept track of the line listing and antibiotic stewardship for the residents, and she was working on the infection listings for the month of February.</p> <p>Review of the facility's Infection Control binder reflected a lack of antibiotic stewardship and infection mapping for December 2021 and January 2022. February 2022 included a map of infection types. The months prior to December 2021 included infection mapping, line listings, and antibiotic use.</p> <p>A review of the facility's policy, Antibiotic Stewardship Program (ASP), revised January 2021, reflected:</p> <p>Background:</p> <p>.According to the CDC, Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Diseases caused by these bacteria are increasing in long-term care facilities and contributing to higher rates of morbidity and mortality. [sic]</p> <p>Policy</p> <p>.This Long-Term Care Facility ASP activities shall, at a minimum, include these basic elements: .tracking measures, reporting data.</p> <p>Procedure: .</p> <p>2. Accountability</p> <p>a. The ASP Team .will:</p> <p>i. Review infections and monitor antibiotic usage patterns on a regular basis .</p> <p>iii. Monitor antibiotic resistance patterns .</p> <p>iv. Report on number of antibiotics prescribed and the number of residents treated each month</p> <p>v. Include a separate report for the number of residents on antibiotics that did not meet criteria for active infection.</p>

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<p>F 0888</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure staff are vaccinated for COVID-19</p> <p>45447</p> <p>Based on interview and record review, the facility failed to ensure staff had a vaccine, exemption, or a delay for the COVID-19 vaccine, at a rate of 100%, for 2 (staff members U and V) of 7 sampled staff members. This deficiency had the potential to increase the incidence of COVID-19 amongst residents and staff in the facility. Findings include:</p> <p>During an interview on 2/16/22 at 1:53 p.m., staff member B stated staff members U and V did not have a COVID-19 vaccine, exemption, or delay, and were in the process of getting their first vaccines. Staff member B stated staff member KK was following up with the staff members who were not compliant with the vaccines, and that all staff were wearing appropriate PPE for the current outbreak in the facility. Staff member B stated if staff members U and V chose not to receive the COVID-19 vaccine or obtain an exemption, they would be unable to work in the facility.</p> <p>Review of the facility's document, COVID-19 Staff Vaccination Status for Providers (Matrix), received on 2/15/22 at 7:30 a.m. by staff member A, reflected staff members U and V were not showing as having a COVID-19 vaccine, exemption, or delay. The total number of staff was recorded at 101, and the facility was 99% compliant with staff vaccinations.</p> <p>Review of the facility's document, Current COVID Outbreak, received on 2/15/22 at 7:30 a.m. from staff member A, reflected 13 residents infected with COVID-19 in the past four weeks. The document reflected three of those infections resulted in a hospital stay, and one resulted in a resident's death.</p> <p>A review of the facility's policy, COVID-19 Vaccination - Healthcare Personnel (HCP), revised 2/7/22, reflected:</p> <p>Policy: .</p> <p>1.HCP will .be mandated* to receive the COVID-19 vaccine unless they have submitted and been granted a religious or medical exemption or they have already received the current recommended vaccine(s), .</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45447</p> <p>Based on observation and interview, the facility failed to ensure an adequate call system was in place due to a non-functioning call light system, so residents could alert staff when assistance was needed, and get a timely staff response, for 12 (#s 3, 8, 21, 23, 27, 28, 29, 30, 34, 39, 41, and 53) of 34 sampled residents. Resident #53 felt a contributing factor for a fall he had was due to the lack of staff response and the call system, and the lack of response to the bell system caused resident frustration and delays in care. Findings include:</p> <ol style="list-style-type: none"> 1. During an interview on 2/14/22 at 3:53 p.m., resident #29 stated he had to ring a bell on his desk, instead of a call light, and it took a while, sometimes hours, for the staff to answer. 2. During an interview on 2/14/22 at 3:56 p.m., resident #21 stated he had a bell to use instead of a call light, and staff did not always answer quickly. Resident #21 stated he had to wait over an hour for staff to answer at times. 3. During an interview on 2/14/22 at 4:00 p.m., resident #8 stated the residents did not have a call bell, and there were times when they had to wait a while for help. Resident #8 stated she did not know when the situation with the call lights would be fixed. 4. During an interview on 2/14/22 at 4:05 p.m., resident #41 stated instead of a call light, she had a bell to call for help. The resident stated if the bell did not get answered, most of the time she would stick her leg outside of her door to get the staff's attention when she needed help. 5. During an interview on 2/14/22 at 4:10 p.m., resident #3 stated he had to wait a while when he rang his bell because the facility was short staffed. Resident #3 stated he went into the hall and flagged down a staff member if his roommate, resident #53, needed help because the staff were taking too long. Resident #3 stated this was a common occurrence. 6. During an interview on 2/14/22 at 4:10 p.m., resident #53 stated the residents had bells to use instead of a call light, and it did not work very well. Resident #53 stated he could ring the bell all day, and the staff did not come at times. Resident #53 stated there was a time where he had to wait a while and fell on his bottom when he was trying to pick a remote up off of the floor. 7. During an observation and interview on 2/14/22 at 4:17 p.m., resident #27 was sitting in his room, with the door slightly open, using his bell to alert the staff that he needed assistance. Resident #27 stated there was no way for a staff member to know his bell had rung unless they heard it. The resident stated he usually had to wait a while, the bell system did not work well, and he had to ring the bell until his arm was sore. <p>During an observation on 2/14/22 at 4:36 p.m., resident #27 continued to ring his call bell, and the closest staff member was down the hallway by the med cart. When the surveyor went to the med cart, the bell sound was barely audible. The surveyor left the hallway after 19 minutes, and resident #27 did not receive a response from staff for the ringing of his bell.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. During an interview on 2/15/22 at 9:06 a.m., resident #30 stated instead of a call light, the facility had him use a tambourine when he needed help. Resident #30 stated when he made noise, the staff did not come quickly.</p> <p>During an interview on 2/16/22 at 9:59 a.m., staff member N stated the call light system had been out of service for almost two months. Staff member N stated the facility was experiencing an increase in resident falls because the residents were trying to reach their bells. Staff member N also stated it caused the residents to be unhappy, and it was a hazard because the staff could not see who was ringing, or tell who needed help if the resident stopped ringing.</p> <p>40068</p> <p>9. During an observation and interview on 2/15/22 at 8:15 a.m., resident #28 was seated in her wheel chair next to her bedside table. On her bedside table there was a bell. Resident #28 stated the facility's call light system was not working. She stated it had been broken for a long time now. She stated she was given a bell to ring when she needed something, however staff members could not hear the bell or did not know which resident was ringing the bell. Resident #28 stated she had felt frustrated because she had to wait a long time for a staff member to come and help her.</p> <p>32997</p> <p>10. During an observation and interview on 2/14/22 at 4:01 p.m., it was observed resident #34's call light was hanging on a metal hook that was screwed into the bookcase up against the wall on the left side of the resident's bed. The call light was above and behind the resident's head. The resident had a hand bell sitting on table next to his bed. Resident #34 said the call lights had not been working for several weeks, probably a month, so staff gave him the hand bell to ring if he needed help. When asked if ringing the hand bell was affective, the resident said, No, they can't hear anything in the hallway or if they're in another resident's room. When asked how he made staff aware he needed something resident #34 said, I yell, usually someone hears me.</p> <p>11. During an observation and interview on 2/15/22 at 7:20 a.m., resident #23 was in her wheelchair watching television. She had a bedside tray table pulled over her lap. Sitting on the table was a bell, similar to a hotel desk bell. Resident #23 said she was waiting for breakfast. When asked about the bell on her table, she said she was supposed to ring it for help. Resident #23 said the facility call lights had not worked in a long time. When asked if staff answered the bell the resident said, No, they can't hear it. Resident #23 expressed frustration with the situation. Resident #23 said she needed help going to the bathroom, and it was hard to get staffs' attention when they could not hear her ringing her bell.</p> <p>12. During an observation and interview on 2/15/22 at 7:53 a.m., resident #39 had a hand bell sitting on his bedside table and he was in his recliner. When the resident was asked about the purpose of the bell he said the call light system was not working, and he was supposed to ring the bell for staff assistance. Resident #39 said the call lights had not been working for a month. When asked if the hand bell was affective in getting the staff's attention the resident said, No, they can't hear it. It's too noisy out there. When asked what he did to get staff's attention for help resident #39 said, I get in my wheelchair, roll to the door, and yell for help.</p> <p>44770</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>13. During an observation on 2/16/22 at 2:18 p.m., A resident in room [ROOM NUMBER] was ringing a bell in the room, then room [ROOM NUMBER] began to ring a bell. At 2:21 p.m., a staff member entered room [ROOM NUMBER] after walking down the hall trying to figure out what room was ringing the bell. At 2:22 p.m., room [ROOM NUMBER] began ringing the bell again. A staff member walked by the room and went into room [ROOM NUMBER] to ask if they needed help. The resident stated, No, I don't know who is ringing. At 2:23 p.m., room [ROOM NUMBER] was still ringing the bell. The wound care nurse walked by wearing her coat to leave, she told the resident that she would be back to help. At 2:25 p.m., the wound nurse returned and helped the resident. At 2:27 p.m., there was someone ringing a cow bell on the 200 hall, it was hard to tell where it was coming from. No staff entered any of the rooms, but the cow bell stopped ringing. Observation ended at 2:56 p.m.</p> <p>During an interview on 2/16/22 at 2:47 p.m., staff member K stated, You just have to keep walking up and down the halls until you can figure out who is ringing the bell.</p>