STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 44770 Based on observation, interview, and record review, the facility failed to assess 1 (#230) of 1 sampled resident for self administration of medication. This deficiency had the potential for medication administration errors for resident #230. Findings include: During an observation on 2/2/23 at 7:46 a.m., staff member Q was in the hall with resident #230, at the medication cart. Staff member Q asked resident #230 how she does her nebulizer treatment. Resident #230 told staff member Q she mixes the medications together and does it herself. Staff member Q had a difficult time finding the medications in the cart. Resident #230 showed the nurse where to find the medications in the cart. Staff member Q handed the medications to resident #230, and the resident went to her room, set up her nebulizer, and started the treatment. There was an inhaler on the resident's nightstand. Resident #230 stated the medication was her Albuterol inhaler, and she administered the medication to herself, every four hours. A self-administration assessment was requested for resident #230. No documentation was provided by the end of survey. Review of resident #230's MAR and Physicians orders failed to show an order for self-administration of medications. Review of resident #230's comprehensive care plan, dated 1/11/23, failed to show resident #230 administered her own medications.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47752 Based on interview and record review, the facility failed to notify a physician of a severe weight loss, for 1 (#39) of 4 sampled residents. Findings include: Review of resident #39's weight documentation showed her weight on 7/19/22 was 172 pounds, and on 1/13/23 was 133 pounds. This was a severe weight loss of 22.67% in 180 days. During an interview on 2/1/23 at 9:45 a.m., staff member V stated weights are only reviewed once a month unless the physician's assistant or physician requests something different. Staff member V stated she was unaware if the physician was notified of #39's weight loss. During a review of resident #39's medical record, no nurses notes were found noting that the physician was notified of the severe weight loss in six months. No notes were found noting that the weight loss was unavoidable. The Physician was unavailable for interview at the time. During a review of resident #39's physicians progress notes for 7/14/22, 8/5/22, 8/19/22, 9/7/22, 9/16/22, 11/16/22, 11/22/22, and 1/9/23, weight loss was not addressed. Please refer to F692, Nutrition/Hydration status Maintenance, for additional details related to severe weight loss for resident #39.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41652 Based on interview and record review, the facility failed to ensure residents were free from any form of abuse for 2 (#s 26 and 430) of 4 sampled residents. Resident #26 stated he felt worthless, and resident #430 was afraid to call for assistance when she needed help. Findings include: 1. Review of a Facility Reported Incident, reported to the State Survey Agency, dated 6/1/22, showed resident #26 reported a CNA yelled at him and had made him feel worthless. Review of the facility investigative file for the incident, which occurred on 6/1/22, and provided by the facility on 1/31/23, showed the facility substantiated the allegation of staff verbal abuse, based on statements by resident #26, the accused CNA, and another unidentified CNA who was present during the interaction. During an interview on 2/1/23 at 4:54 p.m., staff member B stated the accused CNA was immediately suspended, and was going to be allowed to return to the facility, after the investigation, and education was completed. Staff member B stated the CNA did not complete the education and chose not to return to work at the facility after being suspended. 47752 2. Review of a facility reported incident, reported to the State Survey Agency on 6/19/22, showed resident #430 reported a CNA was rude and refused to empty her emesis basin when asked. Also, resident #430 reported the CNA slammed her door whenever she left the room, causing the resident to be tearful, and afraid to ask the CNA for assistance. Review of the 6/19/22 investigation, provided by the facility on 2/1/23, showed the facility substantiated the allegation of abuse based on statements from resident #430, other resident interviews, and staff interviews. The investigation showed the CNA was immediately suspended and terminated after the investigation was completed. The investigation showed the CNA was provided abuse and neglect training at the time of hire. During an interview on 2/1/23 at 9:05 a.m., resident #430 stated she remembered the incident and became tearful. Resident #430 stated she quit asking for help because she was scared the CNA would be mean. Resident #430 was aware the CNA was not longer working at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 40068 Based on interview and record review, the facility failed to investigate a Facility Reported Incident of neglect within the required time frame, for 1 (#400) of 2 sampled residents; failed to thoroughly investigate an allegation of misappropriation of resident property involving a controlled narcotic medication, for 1 (#433) of 1 sampled resident; and failed to provide staff education to address reoccurring allegations of abuse and neglect for 2 (#s 3 and 22) of 2 sampled residents. Findings include: 1. Review of a Facility Reported Incident, sent to the State Survey Agency on 12/20/22, showed: - [Resident #400's] wife spoke with the case manager at [Hospital Name] about concerns she has about her husbands care at [Facility Name]. - Investigation initiated, physician, wife, notified . - What were the results of this investigation? Interview with the nurse on duty 12/18/22 stated she gave morning medications and noon medications and asked, [Resident #400] how he was feeling and resident said he was tired but otherwise felt fine on both occasions. Nurse immediately assessed resident upon wife's request because she thought he was yellow looking and slumped in his chair. The provider was who instructed to send the resident to the ER. The toilet in the residents room has been fixed and was working properly as of 12/27/22. The facility had appropriate staff working the shift. Interviews with other residents indicated there were not times that they were denied use of the bathroom. [sic] -Findings of this investigation were submitted to the State Survey Agency on 12/27/22. The investigation was submitted outside of the five days required for neglect allegations, per CMS regulatory requirements. During an interview on 2/2/23 at 9:10 a.m., staff member A stated the facility needed to work on the facility reported incident investigation process. Staff member A stated there was some confusion on who was supposed to complete investigations. Staff member A stated, Sometimes the DON completes it and sometimes the administrator completes it. My guess is that it just fell by the wayside, when referring to the incident regarding resident #400. 41652 2. Review of a Facility Reported Incident, dated 11/12/22, and reported to the State Survey Agency, showed resident #433 reported a bottle of 8-10 oxycodone tablets, went missing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the investigative file, provided by the facility on 2/1/23, showed the misappropriation of medications was unsubstantiated due to a lack of evidence. The documents showed five other residents were asked about any missing personal items, and all of them denied having anything missing. The investigation failed to show how the facility addressed the scheduled narcotic being in the resident's possession prior to it being stolen, to prevent similar occurrences in the future. The file failed to show any corrective actions or system changes implemented to prevent this type of incident from happening again. During an interview on 2/1/23 at 4:47 p.m., staff member B stated the person who investigated the misappropriation of medication was no longer employed by the facility, so was not available to interview. Staff member B stated there should have been a belongings list in resident #433's EMR, but it was not found. Staff member B stated she believed the resident was not aware he should not have any medications in his possession. Staff member B stated the investigative file failed to show any documentation regarding the risks associated with the missing item being a controlled narcotic medication. 46400 3. During an interview on 2/1/23 at 1:17 p.m., resident #22 stated the night shift CNA [staff member X] was very dismissive of her. Review of resident #22's written statement, included in the investigation file for the November 2022 verbal abuse allegation, dated 11/8/22, showed, Asked CNA [staff member X] if he could take off my [NAME] Hose . he said I'm not doing this. Anything I do for you you are going to complain about .We clash. He's making me very unhappy. Review of the facility investigative file showed a lack of education or monitoring for staff member X upon his return to work. 4. Review of Facility Reported Incidents, dated 9/16/22 and 10/10/22, showed resident #3 accused staff member X of neglect involving one instance of being left on the bedpan, and another instance of being left without his call light. During an interview on 2/2/23 at 8:52 a.m., staff member C reviewed the facility investigation files for resident #3's allegations of neglect in September and October of 2022; and resident #22's allegation of verbal abuse in November of 2022. Both allegations accused the same staff member. She stated the investigation files did not show if education was done for the staff member accused once he returned to work, but she knew the previous DON had completed education for staff member X.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 47752 Based on observation, interview, and record review, the facility failed to implement a baseline care plan which included the minimum healthcare information necessary to properly care for 1 (#430) of 4 sampled residents. Findings include: During an observation and interview on 1/31/23 at 10:04 a.m., resident #430 was sitting in her wheelchair. Resident #430 stated, My needs are not met adequately. Resident #430 became tearful. The resident appeared to have bilateral edema to her lower extremities. Indentation marks from resident #430's socks were present to her bilateral legs, just above her ankles. Resident #430 stated she needed assistance with bathing, grooming, toileting, dressing, and mobility. Resident #430's baseline care plan showed the following: - . (Interim) Resident has potential for bruising, hemorrhage due to anticoagulant use. Review of resident #430's medication administration record, dated January 2023, showed no anticoagulant was ordered. During an interview on 2/1/23 at 10:24 a.m., with staff member G, he stated the baseline care plan was initiated by the nurse on shift when the resident arrived. Record review of the facility policy, Care Plans, dated September 2019, showed: .3. The areas that must be addressed in the base line care plan include: a. Initial goals based on admission orders b. Services and Treatment being provided c. Summary of medications d. Dietary instructions e. Ongoing update to the initial care plan .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47003 Based on observation, interview, and record review, the facility failed to develop an accurate person-centered care plan for 5 (#s 12, 39, 47, 70, and 74) of 10 sampled residents. Findings include: 1. During an observation and interview on 1/31/23 at 10:53 a.m., resident #70 was initially unable to hear the surveyor's questions, even when repeated loudly. The resident reached into his drawer and pulled out a headphone device, placed them over his ears, and gestured to repeat the statements. The resident was still unable to adequately hear. This surveyor increased the volume of his voice and spoke directly into the resident's ear, and into the headphone. Resident #70 stated he had used hearing aids in the past, but one of them had been misplaced at some time. During an interview on 1/31/23 at 4:41 p.m., resident #70 could not hear this surveyor's questions and became visibly frustrated and angry. The questions had to be written on a piece of paper for the resident to effectively communicate and respond. Review of resident #70's Admission MDS, with an ARD date of 12/29/22, showed under section B, Hearing speech and vision: the resident was marked down as yes for using a hearing aid. The sections for ability to hear, ability to express ideas and wants, and understands verbal content, were not filled out. Review of resident #70's care plan, dated 1/19/23, showed the only intervention related to the resident's hearing loss and difficulty communicating was, Make sure the resident wears eyeglasses and/or hearing aids, if applicable. 2. During an observation and interview on 1/31/23 at 9:39 a.m., resident #74 was lying in his bed, with a boot on his right foot, and his right arm was bent at 90 degrees. His forearm was lying on his stomach. While eating his breakfast, the resident attempted to open a sealed container of syrup to put on his cake, with his left hand. The resident bit the corner of the syrup, to peel off top, but ripped the corner off and was unable to open the syrup. The resident stated he did not know how we was going to get the syrup open. He placed the syrup container on his tray and stabbed the syrup repeatedly with his plastic knife, which was in his left hand, until he broke through the seal. The syrup tipped over and poured all over the resident's tray. The resident stated he was not going to eat his cake since he did not have any syrup. Resident #74 stated he was unable to get out of bed or use his right arm, as he had fallen and broken his right shoulder at home, and then had fallen in the facility (1/3/23) and sustained a broken right leg. Resident #74 stated he was normally right-handed and was able to walk at home prior to his injury. During an interview and observation on 2/1/23 at 2:46 p.m., staff member M stated resident #74 was bedbound and required a hoyer (mechanical lift) lift to be moved. Staff member M stated nursing was unaware of anything specific the nursing staff was supposed to be doing for resident #74, after skilled therapy had ended, to prevent pneumonia, atelectasis, or improve range of motion. It was observed resident #74 had an incentive spirometer, and a small weight, sitting in his room on the bookshelf, inside the door. The resident would not have been able to reach it without getting out of bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #74's therapy records showed skilled physical, occupational, and speech therapy stopped on 1/27/23. Review of resident #74's physical therapy discharge summary, dated 1/27/23, showed, chair/bed-to-chair transfer- hoyer lift at this time. Review of resident #74's current provider orders showed, . restorative nursing as indicated by assessment (12/28/2022) . RLE continue non weight bearing, leg to come out boot multiple times a day for ROM . RUE work on ROM (active and passive) and strengthening. [sic] Review of resident #74's current care plan, dated 1/13/23, showed, Requires assistance with ADL's .r/t fx (right) humerus. The interventions showed no person-centered care related to being unable to open various food items, risk prevention measures for being bedbound, daily removal of the boot, exercises for mobility of the broken arm and leg, or requiring the use of a hoyer lift. The resident was not observed to be out of his bed through the duration of the survey. 47752 3. During an observation and interview on 1/31/23 at 9:38 a.m., Resident #39 was wearing oxygen via nasal cannula. The concentrator was set at two liters per minute, and the humidifier bottle was empty. The oxygen tubing was tan/brown in color, not clear, and appeared soiled with debris at the nasal cannula. There was no label with the date when the tubing was last changed. A no smoking/oxygen in use sign was not present in or outside of resident #39's room. Resident #39 stated she had been on oxygen for quite a while now. The resident could not remember the last time the oxygen tubing had been changed. During an interview on 2/1/23 at 8:58 a.m., staff member M stated she was unsure how often oxygen tubing was changed. Review of resident #39's care plan, dated 5/17/22, showed oxygen care and use was not addressed on the care plan. Review of a facility policy, Oxygen Administration, dated September 30, 2022, showed: . Procedures . 2. Review resident's care plan to assess for any special needs of the resident. General Guidelines -Cannula and tubing is changed weekly and as ordered . Equipment . The following equipment and supplies will be necessary when performing this procedure . 4. No smoking/Oxygen in use signs . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41652 4. During an interview and observation on 1/31/23 at 11:05 a.m., resident #12 was sitting in her wheelchair, in her room. Resident #12's breakfast tray was on her overbed table. NF2 was visiting resident #12, and stated her breakfast tray was untouched, and resident #12 needed encouragement and assistance with eating and drinking. NF2 stated resident #12 was always thirsty when she visited, and she wondered if the staff offered fluids to the resident. During an interview on 2/1/23 at 1:12 p.m., staff member D stated she did not know why resident #12 sometimes ate in her room. Staff member D stated if a resident needed help eating, they were brought to the area near the nurse's station, so they could receive assistance during meals. During an interview on 2/1/23 at 1:45 p.m., staff member P stated resident #12 needed assistance to eat and needed encouragement to take fluids. Staff member P stated the only time resident #12 should have been in her room was when she was too tired to get up, and she was assisted with eating in her room. During an interview on 2/2/23 at 8:59 a.m., staff member E stated resident #12 was dehydrated and needed to be encouraged to take fluids. Staff member E stated she was not sure if resident #12's need for assistance with fluids was on the resident's care plan, but it should have been. Staff member E stated when a resident was receiving hospice services, the care plan came from the (hospice) agency providing the services. Staff member E looked for, and could not find, the care plan for resident #12 from hospice. Review of resident #12's care plan, dated 1/8/23, showed a problem with the resident's nutritional status, but there were not goals or interventions documented for needing assistance with eating and drinking. The care plan failed to show any information about the potential for dehydration, or the need to encourage and assist the resident to eat and drink. 44770 5. Review of resident #47's comprehensive care plan, dated 1/12/23, showed resident #47 was admitted on [DATE]. The care plan included a focus area for assistance with ADLs, initiated on 1/12/23, and a focus area for the resident having a risk for falls, initiated on 1/22/23. There were no other focus areas on the resident's comprehensive care plan. During an interview on 2/1/23 at 2:59 p.m., staff member I stated all staff (direct care staff) created care plans. Staff member I stated the comprehensive care plan came from the initial assessment. The comprehensive care plan should have included areas of concern or focus areas for the resident, interventions, and goals. Staff member I stated, The care plan should include anything to do with ADLs, pain, skin, meds, basically anything to take care of the resident. During an interview on 2/1/23 at 3:03 p.m., staff member I was looking at resident #47's comprehensive care plan. There were only two areas of concern listed on the comprehensive care plan. Staff member I stated, I don't know what happened here. There should be way more stuff on this care plan. His initial assessment looks like it wasn't completed, so neither was the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47752 Based on observation, interview, and record review, the facility failed to revise and update a resident's care plan to meet the current needs of catheter care, oxygen, and urinary infections, for 1 (#39), of 4 sampled residents. Findings include: 1. During an observation and interview, on 1/31/23 at 9:38 a.m., resident #39 was lying in bed. There was a strong, urine smell in the room. The urinary catheter drainage bag was uncovered and sitting directly on the floor, with no barrier between the floor and catheter bag. Resident #39 stated she had been getting a lot of urinary infections. She stated she rarely got cleaned up, down there. Resident #39 pointed to her peri area. 2. Resident #39 was wearing oxygen via nasal cannula that was set at two liters per minute. A humidifier bottle was empty. The tubing was a tan/brown color and not clear, and appeared soiled. During an observation on 2/1/23 at 8:48 a.m., resident #39 was lying in bed with oxygen on at two liters, via nasal cannula, and the humidifier bottle was still empty. During an interview on 2/1/23 at 8:58 a.m., staff member M was notified the humidifier bottle was empty for resident #39's oxygen concentrator. Staff member M stated she was unsure how often the oxygen tubing was changed. Staff member M also was notified the catheter bag was sitting on the floor. Staff member M stated resident #39 gets frequent urinary infections, and catheter care was to be completed with resident cares and was changed as needed. During a review of resident #39's treatment administration record, dated November 2022, December 2022, and January 2023, there was a lack of documentation of a catheter change or oxygen tubing changes. During a review of resident #39's care plan, dated 6/10/22, updates and revisions did not occur for oxygen and foley catheter care. There was no updates or revisions made to the care plan after multiple infections. Risk for infections or infection interventions were not added to the care plan. The care plan showed resident #39 continued on skilled care. During an interview on 2/1/23 at 10:24 a.m., staff member G stated with any changes in cares, the care plan should be updated with the correct information, and stated, Everyone has access to the care plan to make revisions. Staff nurses should update the care plan with any changes, but a lot of times they don't do it, they leave it for administration to do. Staff member G stated resident #39 had skilled services discontinued in June 2020. Review of a facility policy, titled, Care Plans dated September 2019, showed: .Resident care conferences are held within the first 72 hours of admission, upon completion of the comprehensive care plan, and at least quarterly thereafter in coordination with the MDS schedule and process. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. After the care conference, if there are any revisions needed, they are made in the EHR care plan .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41652 Based on observation, interview, and record review, the facility failed to provide ADL assistance to residents who required staff assistance with bathing, for 6 (#s 2, 12, 26, 60, 72, and 254) of 11 sampled residents; and failed to provide necessary assistance with eating, for 1 (#23), of 1 sampled resident. The deficient practice resulted in residents not receiving a minimum of a weekly shower. Findings include: 1. During an interview on 1/31/23 at 11:31 a.m., NF2 stated she visited the resident every day. NF2 stated resident #12 needed assistance with bathing. NF2 stated she had requested resident #12's hair be washed so it could be fixed. NF2 stated resident #12 got a bed bath on 1/30/23, but her hair was not washed as requested. NF2 stated she had to wash her hair on 1/31/23 so it could be fixed. Review of resident #12's care plan, dated 1/10/23, showed the resident was to receive assistance with bathing up to twice a week. Review of resident #12's bathing records, dated from 12/27/22 through 2/1/23, showed the resident had been showered once on 1/15/23, and there was one refusal on 12/28/22. The record showed resident #12 had only been offered a shower twice in approximately 30 days, rather than twice per week per her preference. 2. During an interview on 1/31/23 at 12:41 p.m., resident #26 stated he was told by the facility he would be getting two showers a week. Resident #26 stated he got one a week, and said the second shower never happens. Review of resident #26's care plan, dated 8/4/22, showed the resident required assistance with bathing, and he preferred showering twice per week. Review of resident #26's bathing records, dated from 11/1/22 through 1/31/23, showed the resident had 23 opportunities for a shower, and received 11 showers during the months of November and December of 2022, and January of 2023. Based on the information received, resident #26 went without a shower or a bath for more than seven days five times during the timeframe, with the maximum being 13 days between showers. 3. During an interview on 1/31/23 at 11:57 a.m., resident #60 stated she liked having a shower every other day, but the facility told her she would receive two showers per week. Review of resident #60's care plan, dated 12/14/22, showed the resident required assistance with bathing and was to be offered a shower up to twice a week. Review of resident #60's bathing records, dated from November of 2022 through January of 2023, showed the resident had 19 opportunities to shower. The bathing records showed eight showers total were given during the months of November and December 2022, and January 2023. Based on the documentation provided by the facility, resident #60 went 11 days in November 2022 without a shower, and 22 days in late December 2022 and early January 2023 between showers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/1/23 at 1:35 p.m., staff member J stated she worked on Monday, Tuesday, and Wednesday as a bath aide. Staff member J stated she had a resident list which showed each resident's (bathing/shower) preference, and most residents wanted at least two showers per week. Staff member J stated there was not a bath aide scheduled on the days she was not working, so most of the residents only got one shower per week. Staff member J stated the CNA assigned to a resident could try to get a shower or bath done, if she (staff member J) was not able to get at least one done per week. 46400 4. During an observation and interview on 2/1/23 at 1:17 p.m., resident #2 stated it was going on her second week without a shower. Review of resident #2's care plan, dated 10/13/22, showed, I require staff to assist me with 1 to 2 showers per week. Review of resident #2's ADL task Bathing, dated January - February 2023, showed resident #2 had received two showers out of a minimum five opportunities. 5. During an observation and interview, on 2/2/23 at 9:21 a.m., resident #72 stated he was feeling, . miserable. You can't get a shower around here, they keep giving excuses. Resident #72 was wearing sweatpants, and a T-shirt, which had various food and liquid stains on the front of it. Review of resident #72's Bathing Preference Questionnaire, no date, showed, We offer routine bathing two times per week. In the space provided for the resident to detail their bathing preferences, resident #72 wrote: Monday, Wednesday, and Friday is when I like showers. Review of resident #72's ADL task Bathing, for the dates of January - February 2023, showed his last shower was on 1/22/23, 11 days prior. There were no documented shower refusals. 6. During an observation on 2/2/23 at 9:38 a.m., resident #23 was in the dining room eating breakfast. She was alone, with no other residents, or staff, in the dining room to assist her. Review of resident #23's care plan, dated 10/19/22, showed, Eating: I require a 1:1 feeding . I want to be waken about 7. I don't like to be late to breakfast. [sic] 40068 7. During an observation on 1/31/23 at 10:42 a.m., resident #254's hair appeared very greasy, and he had what appeared to be a significant amount of dandruff around his shirt collar. During an interview on 2/1/23 at 10:47 a.m., resident #254 stated staff never asked him if he wanted to be showered. He stated the last time he had a shower was two weeks ago. He stated he would ask for one this week, however he was leaving the facility in a couple days. During an interview on 2/1/23 at 10:49 a.m., staff member N stated the 300 wing did not have a bath aide. She stated staff try and give baths to the residents when they can, and all nurses and CNAs are supposed to share the bathing task. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #254's Bathing Preference Questionnaire, not dated, showed, Question: We offer routine bathing two times per week - Does this meet or exceed your expectations? (answer)Yes . (question) What type of bathing experience do you prefer? (answer) Showers . Review of resident #254's care plan showed, I will be offered bathing up to 2 times per week. Date initiated 2/1/23 . Goal I will be asked to bathe at least two times per week date initiated 2/1/23. If I refuse to shower, re-approach as needed. Date initiated 2/1/23. Offer bathing as ordered. Date initiated 2/1/23. Offer bed baths if I am unwilling to bathe 2/1/23. Review of resident #254's bathing documentation showed, the resident was admitted on [DATE]. From 1/19/23 - 1/31/22 the resident had one bed bath completed on 1/31/22. No refusals were documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40068 Based on interview and record review, the facility failed to update a resident's Physician Order for Life-Sustaining Treatment (POLST) information to a Do Not Resuscitate (DNR), resulting in the failure to administer cardiopulmonary resuscitation (CPR) to a resident who was a full code, for 1 (#77) out of 4 sampled residents. Findings include: Review of resident #77's Montana Provider Orders for Life-Sustaining Treatment (POLST) form, dated [DATE] showed, Section A: Treatment Options: If patient does not have a pulse and is not breathing: Attempt Resuscitation (CPR) . Review of resident #77's nursing progress note, dated [DATE], showed, The hospice from [Name of Hospice] was here today and the paperwork was done as she is now on hospice. Spoke with the representative again this evening and the POA has made her a DNR no CPR and she verbally said to hold her meds especially anything for her blood pressure and to keep her comfortable and she said they would be in tomorrow to officially change the meds and that she would bring in the new POLST by tonight and that the priest would be in by this evening to see the resident. [sic] Review of resident #77's nursing progress note, dated [DATE], showed, deceased note w/out CPR - no pulse, no respirations no bp (blood pressure) .describe pupils: fixed and dilated .cool to touch .hospice . During an interview on [DATE] at 8:14 a.m., staff member M stated medical records lets them know if a resident's code status changed. Staff member M stated if a resident went on hospice services, floor staff would hear about it in report. Staff member M stated, each resident's POLST information was kept in a binder, at the nursing station. During an interview on [DATE] at 8:23 a.m., staff member R stated resident POLST information was completed right away, upon admission. She stated she was in charge of making sure it was done and scanned into the electronic health record system. Staff member R stated she had a spreadsheet on her computer to help her keep track of POLST information. Staff member R stated when the resident, or their representative, came in to fill out their POLST, she took the POLST paperwork and put it on that resident's unit (at nursing station) for the nurse practitioner or doctor to fill out. Then she got the paperwork from the unit weekly and scanned them into the medical record. Staff member R stated she could not find resident #77's updated DNR POLST information, and said it must not have gotten done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44770 Based on interview and record review, the facility failed to change a wound vacuum dressing on a diabetic ulcer, for 1 (#54), of 1 sampled resident, causing the resident increased skin breakdown above her original wound. Findings include: During an interview on 2/2/23 at 8:51 a.m., resident #54 stated having the wound vac treatment helped her wound to heal. Resident #54 stated, The nurses had some confusion in the beginning and didn't know when or how to change it (vac treatment). It went for a while not getting changed, but the wound clinic got it straightened out. Review of a physician order for resident #54, dated 10/18/22, showed: 1. Remove old dressing. 2. Cleanse with NS. 3. Protect the peri-ulcer area with Cavilon. 4. Use versitel/black foam as the primary dressing. 5. Use VacOpsite as the secondary dressing. 6. This order to be carried out 2 times per week . Please send patient with wound vac supplies so we can reapply it, please reapply wound vac when patient returns, set at 125mmHg. Review of resident #54's Wound Clinic Note, dated 11/22/22, showed, [Resident] is being seen today for her reports of new area of breakdown above ulceration. Staff at [Facility] report they have not been changing wound vac as they do not know how often to change it . Review of a Facility Reported Incident, reported to the State Survey Agency, dated 11/25/22, showed, Interviews with nursing staff revealed [Resident #54] had complained of pain to her wound for a few days. Her medication was administered as scheduled per physician orders. Resident was seen at her wound care appointment on Tuesday 11/15/22. She had her wound vac changed at the appointment. The orders revealed the wound vac was to be changed 2 times a week on Thursday and Sunday. The wound vac did not get changed on Thursday 11/17/22. Record review did reveal the wound vac was changed on Sunday 11/20/22. The investigation was substantiated. Education was given to the nurses to follow physician orders on wound care. During an interview on 2/2/23 at 11:03 a.m., staff member C stated there was no additional investigation or documentation for resident #54's wound vacuum incident. The wound care nurse was not available for interview during the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41652 Based on observation, interview, and record review, the facility failed to prevent the development of a Stage 4 pressure ulcer, for 1 (#4), of 2 sampled residents. The deficient practice resulted in a longer stay in the facility for the resident. Findings include: During an observation and interview on 1/31/23 at 1:59 p.m., resident #4 stated he was initially admitted to the facility with a pressure ulcer acquired while the resident was at home. Resident #4 stated he had developed a new pressure ulcer since his admission in January of 2020. When asked the circumstances surrounding the development of the ulcer, resident #4 stated the ulcer, located in the resident's left groin area, was caused by improper use of a lift sling for the electronic lift. Resident #4 stated he could not remember exactly when the ulcer developed, but the resident did say, They (the ulcers) should never have happened. Resident #4 stated he did not have pain associated with the ulcers due to lack of sensation secondary to his paralysis. During an interview on 2/1/23 at 12:49 p.m., staff member F stated resident #4 had a wound vac dressing which had been changed earlier on 2/1/23, and was not due to be changed until 2/4/23, after the end of the survey. During an interview on 2/1/23 at 1:23 p.m., staff member P stated she was caring for resident #4 when the ulcer was found. Staff member P stated she, and another CNA, were transferring the resident using a lift sling. When the sling was pulled out from underneath the resident, staff member P saw an abnormal area of skin on resident #4's groin area. Staff member P stated she immediately reported the area to the nurse. Review of resident #4's nursing progress note, dated 3/3/22, showed staff member E assessed the wound, and documented the area was not present on the previous day (3/2/22). The note showed the wound was the size of a quarter, and the top layer of tissue was sheared back and open. The documentation did not show the stage of the ulcer. Review of resident #4's wound assessment, dated 1/30/23, showed a facility-acquired Stage 4 pressure ulcer, below the resident's left scrotum, which was initially identified on 3/5/22. The wound assessment showed undermining was present, the wound edges were reddened and moist, and there was a moderate amount of odorous drainage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41652 Based on observation, interview, and record review, the facility failed to ensure a resident admitted with limited range of motion and mobility, received necessary services intended to prevent a decline in functional mobility, for 1 (#12) of 9 sampled residents; and failed to provide range of motion or restorative therapy for 1 (#74) of 2 sampled residents. Findings include: 1. During an observation and interview, on 1/31/23 at 11:24 a.m., resident #12 was sitting in a wheelchair, with an obvious head droop, and exhibited limited ROM to her head, neck, and both shoulders. NF2 stated resident #12 had difficulty feeding herself, accessing her fluids, and was not able to transfer without assistance from staff. NF2 stated resident #12 was admitted to the facility in order to gain enough strength to allow her to return to her previous living situation at an assisted living facility. NF2 stated she had not seen resident #12 receive any therapy or ROM exercises since her admission on 12/27/22. During an interview on 2/1/23 at 1:02 p.m., staff member F stated the facility did not have a restorative aide or a restorative program. During an interview on 2/1/23 at 1:47 p.m., staff member D stated ambulation and ROM exercises were not part of her task requirements for resident care. Staff member D stated she did try to do ROM for residents if she saw a resident getting stiff, but there was no schedule for the frequency or number of repetitions. Staff member D stated she did not document when she did this type of resident care. During an interview on 2/2/23 at 9:40 a.m., staff member C stated the facility did not have a restorative program. Staff member C stated all new residents were assessed by therapy services (PT/OT) to determine if therapy services were warranted. Staff member C was unsure if therapy developed exercise programs for new residents or communicated if a resident needed restorative services. Staff member C stated the resident needs were discussed in morning huddles, but core communication, and staff education, was needed to meet the restorative needs of the residents who did not qualify for skilled therapy services. Review of resident #12's EMR, accessed on 2/1/23, failed to show documentation of the provision of range of motion exercises, or any other activities intended to improve the resident's strength and mobility. 47003 2. During an observation and interview on 1/31/23 at 9:39 a.m., resident #74 was lying in bed with a boot on his right foot and his right arm bent 90 degrees at the elbow resting on his chest. Resident #74 stated he was unable to get out of bed, due to a healing fracture in his leg, and he was unable to move his right arm, due to a fracture in his arm. When asked to move his right arm, he declined, and said it would not move because it was broken. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/1/23 at 2:46 p.m., staff member M stated (the staff) was not really doing anything as far as restorative therapy for resident #74, since physical therapy had stopped. Review of therapy records for resident #74 showed skilled physical, occupational, and speech therapy stopped on 1/27/23. Review of resident #74's current provider orders, as of 2/1/23, showed, restorative nursing as indicated by assessment (12/28/2022) .RLE continue non weight bearing, leg to come out boot multiple times a day for range of motion .RUE work on ROM (active and passive) and strengthening. [sic] Review of resident #74's physical therapy discharge summary, dated 1/27/23, showed, prognosis to maintain CLOF = Good with consistent staff follow through .(physical therapy) reviewed pts goals and instruction in performing supine bed exercises to improve blood flow and mobility in (bilateral lower extremities). Pt demonstrates poor carry over on activities likely due to cognitive function. Review of the current care plan for resident #74 showed no interventions or tasks for range of motion or restorative care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44770 Based on interview and record review, the facility failed to prevent falls with significant injuries requiring residents to go to the emergency department, for 3 (#s 47, 229, and 279), of 5 sampled residents; and, #47 had a significant skin tear; #279 had multiple falls and injury to her head; #229 broke open a knee incision and had surgery to clean and repair the incision, and resident #47 was transferring himself to the bathroom independently, due to a lack of staff assistance at the time of the fall. The facility also failed to prevent a fall with fracture to a resident's patella, for 1 (#55), and failed to protect a resident from significant burns, for 1 (#24), of 8 sampled residents. Findings include: 1. Review of a facility reported incident, dated 1/22/23, showed, [Resident #47] had an unwitnessed fall in the main dining room which caused a significant skin tear to his left hand. Due to the significant skin tear, resident was sent to the ER for evaluation and treatment . Review of resident #47's MDS, dated [DATE], with an ARD of 1/4/23, section V0200, showed, resident #47's fall care area was triggered. Review of resident #47's comprehensive care plan showed the resident had a fall on 1/22/23, and fall interventions were added to the care plan. The care plan did not include fall interventions, prior to the fall, on 1/22/23. During an interview on 2/1/23 at 3:03 p.m., staff member I was looking at resident #47's comprehensive care plan. There were only two areas of concern listed on the comprehensive care plan. Staff member I stated, I don't know what happened here. There should be way more stuff on this care plan. His initial assessment looks like it wasn't completed, so neither was the care plan. Staff member I stated, there was a care plan from a previous admission that included falls as a concern, but the new admission care plan did not have falls included until the fall on 1/22/23. 2. During an interview on 1/31/23 at 9:02 a.m., resident #229 stated he fell in his bathroom, and he broke open the surgical incision, which was from his total knee surgery. He stated he got out of bed around 4:00 a. m., to go to the bathroom, and forgot his walker. He made it to the bathroom, but when he got up from the toilet, he fell on to his knee with the incision, and it broke open. He stated he was able to get to his recliner, but then he thought he must have passed out because he woke up with the CNA and the nurse there, and he was covered in blood. He stated he was sent to the hospital, and the wound (opened incision) had to have another surgery to clean it out, a wound vacuum was placed, and then it had to be sutured closed again. During an interview on 2/1/23 at 1:54 p.m., resident #229 stated, There has been four times I have pissed my pants waiting for them to come help. Resident #229 stated, the night he fell in the bathroom and reopened his surgical incision, he couldn't wait any longer, so he went to the bathroom on his own. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some	3. Review of resident #279's EMR, showed the resident was admitted to the facility on [DATE]. Resident #279 had a risk for falls, and the facility was advised by NF3 the resident required close supervision to keep her from falling. Resident #279 fell five times (7/7/22, 7/9/22, 7/12/22, 7/17/22, and 7/22/22) between her admission on 7/6/22 and her discharge to home from the facility on 8/10/22. Resident #279 was sent to the emergency department for two of the falls, for injuries to her head, and a hematoma on her hip. During an interview on 2/1/23 at 12:14 p.m., NF3 stated, She (resident #279) was not being closely monitored. I told them up front that you have to watch her all the time. They did not have enough staff to really watch her the way they needed to. We brought her home. They did finally manage to move her to a room next to the nurse's station and that helped some. She fell more at the facility than she did at home. She also hurt herself more there than at home. They (the facility) did not have the staffing to keep a close enough eye on her. I think she fell seven times there and went to the hospital twice! During an interview on 2/1/23 at 12:18 p.m., NF4 stated, They knew she (resident #279) was confused. She had several falls there, and we have all these bills from her having to go to the ER. They also didn't get all the staples out of her head. After she was home, she kept complaining of pain, and when EMS came to my house, they found two more staples. I can guarantee you no one in my family will ever go there again. She hasn't fallen once since she has been home. After several weeks, they moved her closer to the desk after she fell so many times. I know they were having horrible staffing problems. Review of resident #279's comprehensive care plan, dated 7/6/22, showed resident #279 was at risk for falls, and the resident required frequent rounding. During an interview on 2/2/23 at 8:39 a.m., staff member E stated, Management is who follows up on the falls. We can make suggestions, but management is usually who changes the care plans. We are the ones that fill out the fall report, and we can put suggestions on there, but then management does their thing and makes the changes. During an interview on 2/2/23 at 8:53 a.m., staff member Q stated, We don't have time to look at care plans, you have to understand the staffing around here. Hopefully, we get changes in care information from report, but some nurses are good at giving report, and others are not. I usually just ask the resident how they transfer or what kinds of things we do for them. Like I said, I don't know most of the residents on this hall, so it is easier to just ask them. If a resident has a fall, PCC will put up an alert task for extra charting for three days. The alert does not tell you if there is anything to be done differently to prevent falls. It just means we have more to chart. 33796 4. Review of resident #24's Facility Reported Incident, sent to the State Survey Agency, dated 8/13/22, showed the resident was given a hot cup of coffee during the lunch meal, and it spilled onto his lap. The liquid burn resulted in blisters to both of his inner thighs. The on-call physician was notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of resident #24's facility investigation, not dated, showed Initially the burns were not painful, just slight discomfort noted. However, they became painful as the days passed, and on 8/20/22 the resident went to the ER. (for the burns) The intervention initiated was for the resident to have hot liquids with a lid. The staff were unable to determine where the coffee came from. The nurse who delivered the coffee to the resident said it came from the unit coffee pot. The CNA working the floor stated the coffee in the pot was cold, and the nurse must have put the coffee in the microwave. The nurse stated she did not put the coffee in the microwave. During an interview on 2/1/23 at 1:47 p.m., staff member B stated she had not been aware of the seriousness of the resident's burns, and did not know why education was not provided to staff regarding serving hot liquids. During an interview on 2/1/23 at 1:55 p.m., resident #24 stated the thing that bothered him about the burns was going out for a weekly treatment to the wound clinic. The burns have not healed. He stated the coffee cup fell off of his bedside table onto his lap. Review of resident #24's EMR showed he had continued to require wound care for the inner thigh burns for the last five months. 5. Review of resident #55's Facility Reported Incident, sent to the State Survey Agency, dated 5/31/22, showed the resident had a fall while transferring out of bed using a transfer pole. The fall resulted in a fractured patella. Review of the facility Fall Scene Investigation Report, dated 5/24/22, showed the root cause of the fall with the transfer pole was the bed was too high. The investigation did not show follow-up on why the bed was too high, and interventions to prevent further falls. A safety pole transfer evaluation was requested for resident #55, on 2/1/23 and 2/2/23. The facility did not provide the evaluation. During an interview on 2/1/23 at 1:14 p.m., resident #55 stated he did not remember the fall, but still used the transfer pole.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 41652 Based on observation, interview, and record review, the facility failed to assess a resident's indwelling catheter for removal upon admission, for 1 (#12), of 3 sampled residents; and, failed to provide a bladder retraining program, for 1 (#430), of 4 sampled residents. This deficient practice caused the resident to begin wearing incontinence products and have emotional distress. Findings include: 1. During an observation and interview on 1/31/23 at 11:21 a.m., resident #12 had a Foley catheter bag attached to her wheelchair. NF2 stated she did not know why resident #12 still had the catheter. NF2 stated resident #12 was mostly continent prior to the hospitalization for a respiratory infection. NF2 stated the resident had the catheter placed while she was in the hospital, and it was never taken out. NF2 was not aware of any medical reason for the catheter. Review of resident #12's diagnoses list from the EMR, accessed on 2/1/23, showed a diagnosis of urinary retention. However, review of the resident's discharge summary from the hospital failed to show a diagnosis of urinary retention. Review of resident #12's discharge orders from acute care, dated 12/27/22, showed an order to, Please keep foley in and doing [sic] voiding trial in 10 days. Urinary incontinence was the only genitourinary diagnosis shown on the discharge documents. Review of resident #12's physician orders from the EMR, accessed on 2/1/23, failed to show an order for the voiding trial. During an interview on 2/2/23 at 8:58 a.m., staff member E stated she did not know anything about a voiding trial and as resident #12 was on hospice, it was up to hospice to decide if the Foley should be left in. When notified the resident started on hospice on 1/20/23, staff member E was not able to explain why there was no attempt to remove the catheter between 12/27/22, when the resident was admitted , and 1/20/23 when the resident began receiving hospice services. Review of the facility's policy titled, Catheterization-Urinary, dated 9/20/22, showed the only indications for an indwelling catheter were neurogenic bladder or obstructive uropathy. The policy failed to show anything related to assessing for the removal of an indwelling urinary catheter. 47752 2. During an interview on 1/31/23 at 10:04 a.m., resident #430 stated, I have become more incontinent because I can not get to the bathroom in time, and they do not get to me in time. It makes me feel horrible, like I am an animal. Resident #430 began to cry and stated the CNAs made her feel like her incontinence was her fault. She stated she would put her call light on for help, but nobody comes for a long time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/23 at 4:49 p.m., staff member T stated he tried to complete rounds on his residents every 2-3 hours, but, It's a struggle at times to get to everyone on time. Today I have 18 residents, and I am the only CNA on this hall. The staff member stated he was not aware resident #430 was incontinent. Review of resident #430's care plan did not address any urinary incontinence issues or show a bladder retraining program was in place. Review of resident #430's EMR did not show any notes regarding urinary incontinence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47752 Based on observation, interview, and record review, the facility failed to provide ongoing monitoring and interventions to prevent a severe weight loss of 22.67% in 180 days, for 1 (#39), of 4 sampled residents. Findings include: Review of the weight documentation for resident #39 showed her weight on 7/19/22 was 172 pounds, and on 1/13/23 it was 133 pounds, representing a severe weight loss of 22.67% in 180 days. Resident #39's weight on 12/26/22 was 140 pounds, representing a weight loss of 5.0% in less than 30 days. No weights were documented for the period between 12/26/22 and 1/13/23. No weights were documented for the period of 1/13/23 and 2/2/23. During an interview on 1/31/23 at 9:38 a.m., resident #39's breakfast had just arrived in her room. Resident #39 stated the food was always late, cold, and does not taste good. I never get a different choice; this is what I get. They never warm it up for me when I ask. I get no option for what I want, so I just don't eat. During an interview on 2/1/23 at 9:45 a.m., staff member V stated weights are only reviewed once a month unless the physician's assistant or physician requests something different. Staff member V stated, Resident #39 is on hospice/comfort care. When they are on hospice/comfort care, we don't have to do anything. The weight loss is considered unavoidable, we don't have to justify it. Staff member V stated she was unaware if the physician was notified of the weight loss. During an interview on 2/1/23 at 10:24 a.m., staff member G stated if a resident was on hospice or comfort care there needs to be on order in the EHR, addressed in the physician's progress notes, and a pertinent diagnosis. During a review of resident #39's EHR, there was no physician's order for hospice/comfort care, no physician's progress note addressing hospice or comfort care, no physician's note addressing weight loss, and no diagnosis indicating resident #39's weight loss was unavoidable. Record review of a dietary and progress note for resident #39, dated 10/27/22 showed: - .Data: WEIGHT WARNING VALUE: 138.0 VITAL DATE: 2022-10-17 16:46.00 -7.5% change [19.8%, 34.0] -10.0% change [29.9%, 59.0] Action: Monthly (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Dx includes: sepsis, UTI, obesity, T2DM, GERD Ht: 67 Wt: 138# IWR: 121-149# BMI: 21.6 (low normal) Response: Nutrition care to comfort . - .Weight change note: Wt trends: Still trending down since 5/25/22 Lost >7.5% in 3 months, lost > 10% in 5 months - .ENN still not being met. Noted refusals from resident for PO intake. When resident does eat poor PO intake. Recommend resident have food to comfort care. RD to monitor until next review . [sic] Review of resident #39's meal intake, showed from 1/4/23 to 2/1/23, the resident had no refusals of meals. During an interview on 2/2/23 at 9:02 a.m., staff member I stated resident #39 was, Not on hospice or comfort cares as far as I know. I do know that we are now working on getting a diagnosis for unexpected weight loss from the physician. Review of resident #39's physician's progress note, dated 7/14/22 at 5:28 p.m., showed, .Palliative evaluated but son is not ready for comfort measures at this time. He knows that she has very little time left . Refer to F580 - Notification of Changes, for more information related to the lack of notification to the physician for the weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47003 Based on observation, interview, and record review, the facility failed to provide an adequate number of staff to provide timely responses to requests for care for 14 (#s 3, 15, 20, 21, 26, 27, 29, 36, 37, 56, 229, 230, 235, and 429) of 15 sampled residents, which included several residents dependent on nursing staff for care. This failure caused a decrease in bathing for resident #21, resident #229 and #26 to have episodes of incontinence, resident #230 to have a decrease in bathing and to receive her pain medications late, resident #235 to have a decrease in bathing and had the potential to negatively affect care for all residents of the facility. It was identified some residents were waiting over an hour to receive assistance from staff. Findings include: During an interview on 1/31/23 at 9:05 a.m., resident #29 stated he was irritated and had filed a complaint for the previous evening when a CNA had taken him to the bathroom, and then they did not want anything to do with him for the rest of the shift. Resident #29 stated when he did use his call light no one came to answer it. During an observation and interview, on 1/31/23 at 9:22 a.m., resident #37 was in her room, sitting upright in a chair, wearing a clothing protector. The resident was waiting for her breakfast. The resident stated she had been waiting quite a while for her breakfast to arrive, and the facility did not seem to have enough caregivers to get things done in a timely fashion. Her breakfast was delivered at 9:35 a.m. During an interview on 1/31/23 at 1:51 p.m., resident #36 stated many residents were complaining about very long call light times, of greater than 30 minutes, before being answered; or, or calls being answered and then not having staff return to provide care, requiring another call. The previous night she had her call light go unanswered for over 30 minutes, and when she went out into the hallway to see if a nurse was available, she noticed several other residents in her hall had their call lights on as well, including a resident that was quite dependent on nursing staff for help. During an interview on 2/1/23 at 1:25 p.m., staff member W stated many of the residents complained about how long it took the staff to answer call lights. She said there were frequently instances when the nursing staff were caring for a fully dependent resident requiring one or two staff for assistance that took a significant amount of time; and as such, were unable to leave to answer other resident calls. She stated the facility recently had several resident care staff quit very quickly after their first shift, due to an inability to deal with the overwhelming amount of resident care, and work required during the shift. During an interview on 2/1/23 at 2:46 p.m., staff member M stated there were not enough staff to adequately provide care, and sometimes basic tasks such as turning bedbound residents or various assessments were often not completed timely or held due to staff not having enough time to accomplish all the work required. She stated, when staff complained to management about feeling there was not enough staff to be able to properly care for residents, or when there was a sick call (employee out ill), the facility would tell them to just figure it out. When a supervisor sat down at the nursing station, where the interview could be heard, staff member M stated she did not want to say anymore, and stated, I don't get in trouble. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/2/23 at 8:54 a.m., staff member A stated the facility expectation was a call light should not go unanswered for more than 15 minutes. Staff member A stated the amount of staff was determined by a corporate matrix, and it appeared the facility staffing was within the parameters of the matrix. Staff member A stated the facility was aware of the long call light wait times, but felt like the issue was staff not using their time wisely and needing more education. Staff member C stated there were several residents who required two staff members to assist with cares, and it was not reasonable for staff to leave to answer call lights, while assisting those residents. Staff member C stated everyone in the facility would answer call lights, even the maintenance employees, but they could not provide anything beyond answering the call light if the resident required nursing care. Review of the facility's form CMS-672, dated 1/31/23, showed: - 67 residents required assistance of one or two staff for dressing; and, 22 residents were fully dependent; - 74 residents required assistance of one or two staff for toilet use; and, 15 residents were fully dependent; and, - 69 residents in were in a chair most/all the time; and nine residents were bedfast Review of sampled facility call light wait times, for seven 24-hour time periods, from 1/6/23 to 1/30/23, showed: - Resident #229 - six wait times greater than 15 minutes, with the longest wait time of 49 minutes; - Resident #230 - 28 wait times greater than 15 minutes, with a longest wait of 70 minutes; - Resident #235 - six wait times greater than 15 minutes, with a longest wait of 78 minutes; - Resident #20 - 16 wait times greater than 15 minutes, with a longest wait of 85 minutes; - Resident #56 - seven wait times greater than 15 minutes, with a longest wait of 52 minutes; - Resident #429 - 12 wait times greater than 15 minutes, with a longest wait of 88 minutes; - Resident #29 - 14 wait times greater than 15 minutes, with a longest wait of 38 minutes; - Resident #3 - nine wait times greater than 15 minutes, with a longest wait of 69 minutes; and, - Resident #27- two wait times greater than 15 minutes, with a longest wait time of 44 minutes. Of the 23 longest wait times identified through the sampled days from 1/6/23 to 1/30/23, 20 (87%) occurred between 6:00 a.m. and 6:30 p.m., which were the day shift hours for the facility. 33796 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Some	Review of a Facility Reported Incident, sent to the State Survey Agency, dated 11/6/22, showed resident #26 stated she felt like she was choking on a piece of ham, and turned her call light on. The light was not answered for 40 minutes. Five residents were interviewed as part of the facility investigation, and two residents said the call lights had a long wait time to be answered. During an interview on 1/31/23 at 11:50 a.m., resident #26 stated staffing and call lights were still a concern. She stated six call lights were on the night before with no staff to answer them. This could not be verified through staff interviews or review of the schedule. Resident #26 also stated some staff nurses would not answer call lights. During an interview on 2/1/23 at 11:10 a.m., resident #15 stated she wrote a grievance regarding staff coming to her room when the call light was on, the light would be turned off, and the staff would not return. She stated she could not walk, and she was dependent on staff for her toileting needs. She stated the long call light times have caused her to be incontinent of bowel and bladder. 44770 During an interview on 1/31/23 at 9:24 a.m., resident #21 stated he would like to have more showers, but the facility did not have enough staff to get the showers done. Review of resident #21's comprehensive care plan, dated 4/5/18, showed resident #21 preferred three showers per week. Review of resident #21's bath record, from 1/1/23 to 1/31/23, showed resident #21 received eight showers out of 27 opportunities, and there were no refusals documented. During an interview on 2/1/23 at 1:54 p.m., resident #229 stated, There has been four times I pissed my pants waiting for them to help. NF5 said resident #229 has never had a problem with incontinence. She stated he just can't wait that long all the time. She stated he waited for a long time when he used his call light; and sometimes, they came in and told him there were other people ahead of him, and turned the call light off. During an interview on 2/1/23 at 9:26 a.m., resident #230 stated, I was having to wait too long to go to the bathroom, so I had to become self-sufficient in here (the facility). Some days I feel neglected here. Last night, they only gave me chicken. When I asked for some salad, they told me the kitchen was closed. One nurse brought me the wrong inhalers because there is another resident with the same initials as me. I cry at least one time a day over something going on here. I had to wait 45 minutes for my pain medication last night. I don't get showers on a consistent schedule. They said we would get showers twice a week. I refused showers a couple of times, but that was because I was in too much pain, and they had not given me my pain medication on time. They did not come back and offer another shower after the medication kicked in. There just isn't enough staff here to take care of all of us. Review of resident #230's late medication audit, dated from 1/1/23 through 1/31/23, showed resident #230's oxycodone was over one hour late 24 times and over 30 minutes late 36 times. Review of resident #230's bath record, dated from 1/12/23 through 1/31/23, showed the resident received two showers, and refused two showers, out of five opportunities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview, on 1/31/23 at 9:40 a.m., resident #235 stated, I have only had one shower, and I am supposed to get one two times a week. Resident #235 said she was admitted to the facility on [DATE]. Resident #235 stated, I feel hot and sweaty, and I get sinus headaches when I don't get a shower often enough. They don't even give us a bed bath. I asked once, and they told me they were too busy. I get told there are 'two or three people ahead of you,' when I use my call light. Resident #235's hair appeared unkempt and had a hair clip that was falling out. Review of resident #235's bathing record, dated from 1/10/23 through 1/31/23, showed the resident received two showers out of seven opportunities. During an interview on 2/2/23 at 8:53 a.m., staff member Q stated, We don't have time to look at care plans. You have to understand the staffing around here. I had to take over this cart (medication) in the hall that I don't know hardly anyone, and there is over twenty people here that I have to give meds to. Most nurses won't even do this job anymore because it is just too hard since there isn't enough staff. Hopefully, we get changes in care information from report, but some nurses are good at giving report, and others are not. Sometimes we don't even have time for any report. I usually just ask the resident how they transfer or what kinds of things we do for them. Review of the Resident Council Minutes, dated 8/8/22, showed the residents stated they were turning their call lights on, and not getting a timely response. They also stated they felt bad when reporting grievances related to the concerns. Review of the Resident Council Minutes, dated 9/8/22, showed Less and less showers are being given. Review of the Resident Council Minutes, dated 10/3/22, showed Copper [NAME] - only 1 CNA, need more help. Review of the Resident Council Minutes, dated 11/10/22, showed the call lights were getting turned off, and then staff left. This is still happening. Review of the Resident Council Minutes, dated 1/12/23, showed Call lights are getting turned off by CNA's, leave and don't return. Residents are having to wait too long for their call lights. During an interview on 2/1/23 at 3:50 p.m., staff member A stated it was the responsibility of each department to address resident council concerns, but she may need to provide the oversight in the future.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 47752 Based on observation, interview, and record review, the facility failed to provide assistance in obtaining mental health services, for a resident who felt she was a burden, was tearful, and anxious, for 1 (#430), of 4 sampled residents. Findings include: During an observation and interview, on 1/31/23 at 10:04 a.m., resident #430 became tearful and anxious stating she did not want to be in the facility. The resident stated she can still live and care for herself with minimal assistance. Resident #430 stated, I am on a waiting list for an assisted living place, but that could take forever. During an interview on 1/31/23 at 4:49 p.m., staff member T stated he was unsure of how to address the anxiety and tearfulness of resident #430. Staff member T stated, I could check with the nurse. During an observation and interview on 2/1/23 at 9:05 a.m., resident #430 became tearful and anxious, and stated, I had to wait over an hour for any kind of help in the middle of the night. Resident #430 stated, I am such a burden. I hate this. My family doesn't want me. I'm just stuck. I have no where I can go. During an interview on 2/1/23 at 8:40 a.m., staff member U stated if a resident was tearful, she tried to talk with them and comfort them. She also stated she would notify the social worker. During an interview on 2/2/23 at 7:58 a.m., staff member Q stated if a resident was tearful, We would attempt to look at the care plan if there was one, or talk to the Social worker. During an interview on 2/2/23 at 9:53 a.m., staff member H stated resident #430's discharge plan was to eventually go to an assisted living facility. Staff member H stated she was aware resident #430 had an anxiety and depression diagnoses. Staff member H stated, Nothing is being addressed at this time for mental or emotional issues, there is no mental health counselor for residents that are skilled (care). We have a counselor that comes in and does long term care. We have a contract with [Provider], but they just do medication management, not therapy. I have no mental health resources available currently. We cannot meet the psychosocial needs of our residents at this time. During an interview on 2/2/23 at 10:10 a.m., staff member C stated she was unaware of any mental health services for skilled residents. The social worker would know what services are available or not. Review of resident #430's progress notes did not show any notes addressing mood. Review of resident #430's care plan did not show any information on how to address the resident's psychosocial well being or mood.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41652 Based on interview and record review, the facility failed to ensure medication irregularities identified by the pharmacist were addressed by the provider, for 1 (#48), of 5 sampled residents. Findings include: Review of resident #48's medication regimen review, dated 8/8/22, showed the pharmacist had recommended a gradual dose reduction on quetiapine and sertraline, both medications used for depression. The pharmacist documented the provider declined the recommendation but did not document the rationale for declining the dose reduction. Review of resident #48's medication regimen review, dated 9/8/22, showed a recommendation for a gradual dose reduction because there had been no documented behavioral symptoms in the previous 30 days, and there was a decline in cognition and ADLs. Review of resident #48's provider progress notes, dated 10/17/22 and 12/7/22, failed to show any documentation of the rationale for declining the recommended dose reductions. During an interview on 2/2/23 at 9:29 a.m., staff member C stated the pharmacist's medication regimen reviews were sent to the DON. The DON put the recommendations in a binder, so when the provider came to the facility to see residents, they could look at the pharmacy recommendations and address them with progress notes or order changes. Staff member C stated when the recommendations were not addressed, the DON should have been following up with the providers. Staff member C stated the previous DON was no longer employed by the facility, and she was not sure if the DON had been following up. Staff member C stated she was currently responsible for oversight of the medication regimen review process and was going to be following up going forward.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 41652 Based on observation, interview, and record review, the facility failed to ensure a resident was free from significant medication errors for 1 (#432) of 1 sampled resident, which resulted in a resident experiencing a seizure related to the cumulative effect of the wrong dose for three days. Findings include: 1. Review of an incident reported to the State Survey Agency, dated 7/17/22, showed resident #432 was administered an incorrect dosage of aripiprazole, an antipsychotic medication, on 7/14/22, 7/15/22, and 7/16/22, and experienced seizure-like activity on 7/17/22. Review of the investigative file associated with resident #432s medication incident, provided by the facility on 1/31/23, showed the following events: - resident #432's discharge orders from acute care, dated 7/13/22, showed an order for aripiprazole 5 mg tablet, Take 1 tablet by mouth every day 7 days, then take 2 tab(s) by mouth daily thereafter, - resident #432's physician orders, dated 7/13/22, and entered into the EMR by staff member F on 7/13/22 at 4:09 p.m., showed aripiprazole, Give 5 mg by mouth one time a day related to OTHER SYMPTOMS AND SIGNS INVOLVING COGNITIVE FUNCTIONS AND AWARENESS (R41.89) for 7 Days AND Give 10mg by mouth one time a day related to .(R41.89), - resident #432's MAR, dated July of 2022, showed the resident received a total of 15 mg of aripiprazole on 7/14/22, 7/15/22, and 7/16/22, and - resident #432's nursing progress note, dated 7/17/22, showed the resident had a seizure on 7/17/22 and the aripiprazole order was entered incorrectly resulting in a larger dose being administered, the aripiprazole was discontinued, and the resident's anti-seizure medication was restarted. Review of resident #432's nursing progress note, dated 7/17/22, showed the resident had been tapered off Keppra (an anti-seizure medication) recently, and the provider was unable to determine if the seizure was an adverse reaction to the high dose of aripiprazole or the recent tapering of Keppra. During an interview on 2/1/23 at 4:38 p.m., staff member B stated the incident was investigated by the previous DON who was no longer employed by the facility. Staff member B stated the entry error by staff member F resulted in a larger dose of aripiprazole being given to resident #432. Staff member B stated admission orders were supposed to be double checked by a second licensed nurse, and there was no documentation showing the double check had occurred. Staff member B stated she had left a message with the consultant pharmacist, but had not heard anything back regarding why the entry error was not identified during the medication regimen review which was done shortly after admission. 44770

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 33796 Based on observation and interview, the facility failed to have adequate dietary staff to efficiently and safely carry out the functions of the dietary department, affecting the residents' quality of life and nutritional services of the residents. Findings include: During an observation on 1/31/22, the dining room trays were not served until 12:49 p.m. The posted meal times showed lunch at 12:00 p.m. The last halls trays were delivered at 2:38 p.m. During an observation on 1/31/22 at 12:55 p.m., an upset resident stated he would like to 'chew my ass' if I were from the kitchen, because he had still not gotten any lunch. He had four slices of toast on his lap. He did not provide his name. During an interview on 2/2/23 at 10:12 a.m., staff member Y stated the kitchen was not fully staffed, and she had been working as a night aide for quite a while. She stated she did sanitation rounds in the kitchen but none were documented. She stated there was not enough staff to keep the kitchen clean. The facility was looking to hire two more dietary aides and one cook. She stated most weekends she only had one dishwasher, so ensuring proper hand hygiene between dirty and clean dishes was a concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 33796 Based on observation, interview, and record review, the facility failed to provide food with the correct and safe diet texture, as ordered by the physician, placing the resident at risk for choking and inadequate intake, for 1 (#33), of 8 sampled residents. Findings include: Review of resident #33's physician diet order, dated 4/26/22, showed Level 2 mechanical soft solids, minced meats with gravy. During an observation of lunch, on 1/31/23 at 12:50 p.m., resident #33 received a whole rice krispee bar, which she could not eat. She was observed to have no teeth. Review of the menu spreadsheet for the lunch meal showed residents on a Dysphagia level 2 diet texture should receive a pureed or slurried peanut butter cookie instead of the rice krispee bar. During an observation on 1/31/23 at 5:29 p.m., resident #33 received regular green beans, with no modification to the beans, as the side dish. The menu spreadsheet showed the Dysphagia level 2 diet should have received a soft and chopped or mashed vegetable. During an observation of breakfast on 2/1/23 at 8:30 a.m., resident #33 received an English muffin sandwich with a whole slice of ham. She was unable to eat the sandwich, and had it torn apart with her fingers on the table and the plate. She was attempting to gum the pieces of the sandwich. Review of the facility menu spreadsheet, for the breakfast meal, on 2/1/23, showed residents on a Dysphagia level 2 diet should receive a pureed breakfast sandwich. During an observation and interview of lunch on 2/1/23 at 12:32 p.m., resident #33 received turkey that was served in one inch chunks. She was attempting to eat the turkey and could not. She tried to cut the turkey with a knife while she held the turkey piece in her hand. She stated she could not cut the turkey. Staff member Y was requested to come to the table to look at resident #33's turkey. She stated the family had signed a waiver to allow the resident to eat a regular textured diet. She did not know why the physician diet order did not reflect the regular texture. The facility was not able to provide a waiver for #33's upgrade in texture for her meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33796 Based on observation, interview, and record review, the dietary department failed to maintain a sanitary kitchen to provide safe meals for the residents. Findings include: Observations and interviews of the kitchen on 1/31/23 at 10:27 a.m., the following was identified: 1. The freezer showed a temperature of 40 and 41 degrees. During an interview on 1/31/23 at 10:30 a.m., staff member Z stated the freezer had quit working the day before. He stated he called management at 6:58 a.m., on 1/31/23, to report the freezer not working. During an interview on 1/31/23 at 10:57 a.m., staff member A stated she was aware of the broken freezer, and stated the maintenance man thought he could fix it. She stated, We should probably check on it. During an observation on 1/31/23 at 11:50 a.m., the freezer temperature was 36 degrees. The maintenance manager stated the freezer was good. During an observation on 1/31/23 at 2:06 p.m., the freezer temperature was 26 degrees. During an interview on 2/1/23 at 9:32 a.m., staff member Y stated she had called the maintenance man the night of 1/30/23 and told him the freezer was not working. He told her to unplug and plug the freezer back in. She thought the freezer temperature was going down, and she left for the night. She noted the temperature of the freezer was 20 degrees during the middle of the day on 1/30/23. The facility did not have a temperature log for the freezer. During an interview on 2/2/23 at 9:32 a.m., staff member Y stated she did not know what else her staff could have done to ensure the safety of the frozen foods, but staff member Z had stated the meat was still frozen. 2. During observations on 1/31/23 at 10:27 a.m., 24 boxes of groceries were dispersed on the floor in the freezer, next to the freezer, and in the dry storage area. 3. The can opener was coated with 1/8 inch of old dark liquids, which was around the six inches of the opener's metal edges. The can opener blade was coated with food grime. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. The rotating toaster oven, which was in use, had rust on it. The stove top burners had burnt cheese on them. The microwave handle was crusty, and the inside of the microwave had food spills. A fan above the cooking station was coated with dust. The beverage cooler had red spills on the bottom tray. The handles were crusty to the touch. Two types of air filters, which were sitting on the floor, were dusty, and had food spills. The kitchen aide mixer was soiled with food and dust on the outside. The cooks prep area, next to the stove top, had crumbs and grease on it, and both the top and bottom shelf. 5. During an observation on 2/2/23 at 9:25 a.m., staff member Z was observed eating a sandwich at the cook's prep station. He placed the sandwich on the upper shelf, and preceded to prepare raw chicken for baking, with his hands which were not washed. 6. During an interview on 2/2/23 at 9:30 a.m., staff member Y stated she knew the kitchen was dirty, and the department did not have the staff to keep on top of cleaning. Staff member V stated the dietary department was in survival mode and were focused on preparing meals for the residents. The dietary department had no documented sanitation rounds. The cleaning schedule posted on the wall did not include the above areas to be cleaned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41652 Based on interview and record review, the facility failed to ensure physician progress notes were received and scanned into the individual resident EMRs, timely, for 1 (#48), of 6 sampled residents. The deficient practice had the potential to affect all residents residing in the facility. Findings include: During the review of documents related to psychotropic medication management, the EMR for resident #48, accessed on 2/1/23, failed to show any provider progress notes for the provider's routine visits since March of 2022. A written request for provider progress notes was submitted to staff member A on 2/1/23. Staff member A stated the medical records department was behind on scanning documents into the EMR. Staff member A stated they (the facility) would have to request the notes directly from the provider's office. Review of the documents requested, received on 2/2/23, showed the notes were faxed from the provider's office on 2/2/23 between 9:02 a.m. and 9:35 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 41652 Based on interview and record review, the facility failed to maintain an arbitration agreement that explicitly granted a resident or the resident's representative the right to rescind the agreement, within 30 days, of signing the agreement. This failure would affect all new residents being admitted . Findings include: During the survey entrance conference interview, on 1/31/23 at 8:50 a.m., staff member A and B stated they were not sure if the facility had new resident admissions sign an arbitration agreement. Review of the facility's Admission Agreement, not dated, showed an arbitration agreement, not dated, which showed the resident, or the resident's representative, had five (5) business days from the execution of the agreement to cancel the agreement. During an interview on 2/1/23 at 4:38 p.m., staff member B stated she had discussed the arbitration agreement concern with staff member A and determined the facility did have a voluntary arbitration agreement, which had been a part of the admission agreement, since July of 2022. When shown the five day timeframe for canceling the agreement, staff member B stated she was not aware of the 30-day timeframe for the regulatory requirement, S483.70(n)(3), of the State Operations Manual, Appendix PP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. Building B. Wing	02/02/2023

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44770 Based on observation, interview, and record review, the facility failed to maintain proper infection control practices regarding nursing staff failing to wear masks while caring for 1 (#5) of 1 sampled resident; and failed to wear masks in care areas of the facility. The facility was in COVID-19 outbreak status during the survey with three active resident cases of COVID-19. This deficient practice had the potential to spread infection throughout the facility. Findings include: During an interview on 1/31/23, at 7:45 a.m., staff member A stated there were three positive COVID-19 residents in the facility at the time of state survey entrance. Review of a facility reported incident, dated 12/2/2022 at 6:00 p.m., showed: Incident Description- [Resident #5] complains of mistreatment to him and other residents because 2 nurses do not wear their masks when they work the night shift, and he was given COVID 19 because of it. HE is fearful of dying and angry at the facility for allowing this to happen. The 2 nurses were suspended pending the investigation The provider was notified and the investigation begun. The resident is his own representative. FINDINGS- submitted on 12/07/2022: [Resident #5] had complaint of two night shift nurses not wearing their masks when they work which is causing him to fear for his life. The two nightshift nurses accused were suspended and an investigation was immediately initiated. Upon investigation it was found that these two nurses were in fact at times not wearing their masks as per facility protocol. Therefore both nurses were educated on the importance of wearing their masks and given teachable moments. [Resident #5] is his own responsible party and aware of the investigations outcome. Provider made aware as well. [sic] During an observation on 2/2/23 at 8:39 a.m., staff member E was standing at the medication cart at the nurses' station. Staff member E was observed wearing her mask on her chin. The mask was not covering her mouth or her nose. Staff member E pulled her mask up over her nose and mouth when she saw the survey team member in the hall. During an interview 1/31/23 at 2:12 p.m., resident #5 stated he reported two staff members for not wearing masks. Resident #5 stated he had reported the same two staff members twice for not wearing masks. 47752 During an observation, and interview, on 2/1/23 at 9:00 a.m., staff member E was sitting at the nurses station with two other staff members with her mask down. Staff member E stated the policy allows them to have our masks down if no one was around. Staff member E stated her mask should have been up with the other staff members present. During an observation on 2/1/23 at 1:52 p.m., at 2:06 p.m., and 4:17 p.m., staff member E had her mask down at the nurses station with other staff present.