STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275103	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Care and Rehabilitation	2400 Continental Dr Butte, MT 59701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997 Based on observation, interview, and record review, facility staff neglected to ensure system processes were in place to comprehensively assess all residents in the facility; neglected to complete Admission, Annual, and Significant Change MDS assessments which would identify medical and health concerns and care needs, and assist with the development of individualized care plans; neglected to develop and implement comprehensive care plans to address all residents' care concerns for 14 (#s 1, 3, 5, 20, 23, 34, 42, 47, 48, 73, 77, 78, 79, and 80) of 14 sampled residents; neglected to delegate or employ a staff member to complete facility residents' MDS assessments; and neglected to revise resident care plans in a timely manner with residents' care concerns the facility had identified; neglected to monitor for rectal bleeding for 1 (#79) of 1 sampled resident; neglected to assess and document progression of a wound for 1 (#48) of 1 sampled resident; neglected to identify an insidious severe weight loss for 1 (#73) of 6 sampled residents; and neglected to have a process in place to identify severe weight loss for 2 (#s 44 and 78) of 6 sampled residents. Findings include: On 9/15/22 at 8:00 a.m., an Immediate Jeopardy was announced to the facility administrator for the area of Abuse/Neglect - F600, which put all 58 residents at significant risk of harm, therefore was cited at a scope and severity of L. 1. During an observation on 9/13/22 at 11:01 a.m., resident #73 was in bed, and covered by a sheet. A bedside table was over the resident's lap. The resident appeared to be asleep. Resident #73's complexion was very pale. The resident had a long, unkempt beard, and long hair. Resident #73's arms were on top of the sheet, and the resident was not wearing a shirt. The resident's arms appeared flaccid, and without muscle tone. During an observation on 9/15/22 at 3:25 p.m., resident #73 was in bed, and appeared to be asleep. The resident was covered by a sheet. The resident was pale and unkempt. During an observation on 9/16/22 at 7:38 a.m., resident #73 was being wheeled from the elevator onto the main floor by a staff member. The resident appeared to be unkempt. Resident #73 did not respond to a morning greeting. During an interview on 9/14/22 at 10:33 a.m., NF2 expressed concerns regarding resident #73. NF2 said resident #73 was in bed all the time, and resident #73 would mess himself and it took staff a long time to come change resident #73. NF2 said resident #73 was not eating his meals. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of resident #73's monthly weight record from January 2022 to June 2022 showed: - 1/9/22 230.0 pounds, - 1/23/22 202.6 pounds, - 2/14/22 177.6 pounds, - 3/20/22 167.8 pounds, - 3/22/22 171.8 pounds, - 3/28/22 170.8 pounds, - 4/4/22 172.0 pounds, - 5/16/22 171.0 pounds, and - 6/23/22 163.0 pounds. Resident #73 lost 40 pounds from 1/9/22 to 6/23/22. This was a severe weight loss of 19.7 % in six months. Facility staff neglected to identify an insidious severe weight loss for the resident. During an interview on 9/14/22 at 2:38 p.m., staff member G was not aware of resident #73's insidious, severe weight loss. Staff member G did not know if resident #73's physician had been notified of the severe weight loss. Staff member G said nursing staff were supposed to notify the physician of weight changes. Review of resident #73's MDS (minimum data set) showed the facility had started an Admission MDS, with an ARD (assessment reference date) of 11/24/21, showed it was still in progress. The Admission MDS had not been completed. The facility failed to complete a comprehensive assessment of resident #73 at any point during the resident's stay at the facility. This failure led to the facility's inability to develop, and implement an effective, person-centered care plan for resident #73. 2. During an observation on 9/12/22 at 4:22 p.m., resident #78 was in his room watching television. When asked how the resident was doing he responded with Okay. The resident did not respond when further questions were asked. Review of resident #78's monthly weight record, from 5/10/22 to 6/23/22, showed the resident had lost 14 pounds in one month. This was a severe weight loss of 6.74 % in one month. During an interview on 9/14/22 at 2:38 p.m., staff member G was not aware of resident #78's severe weight loss. Staff member G did not know if resident #78's physician had been notified of the severe weight loss. Staff member G said nursing staff were supposed to notify the physician of weight changes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of resident #78's Admission MDS, with an ARD of 5/14/22, showed it was still in progress. The Admission MDS had not been completed. The facility failed to complete a comprehensive assessment of resident #78 at any time during the resident's stay at the facility. This failure led to the facility's inability to develop, and implement an effective, person-centered care plan for resident #78. During an interview on 9/14/22 at 2:38 p.m., staff member G said nutritional assessments were supposed to be completed on a resident's admission, quarterly, annually, and with a significant change. Staff member G said he completed Section K of the MDS, and in the normal course of things he would write the nutritional care plan. Staff member G said the facility used to have a nutrition at risk team that met weekly to review resident weights to check for resident weight losses or weight gains. Staff member G said that team had not met in a long time. Staff member G said for the nutrition at risk meetings he would run a weight summary report, and it would show if residents triggered for weight loss or gain for the last 30, 60, and 90 days. Staff member G said he was not aware of the insidious severe weight loss experienced by resident #73. Staff member G said he was not aware of the severe weight loss resident #78 had experienced. During an inteview on 9/15/22 at 9:16 a.m., staff member B said she understood completion of Admission, Annual, and Significant Change MDS care area assessments was an important component to developing accurate, effective, person-centered care plans. Staff member B said she understood if this process was not completed facility staff would not be able to identify and provide the care needed for the residents residing in the facility. 45448 3. During an observation on 9/12/22 at 12:31 p.m., resident #44 was seated in the secured unit dining room. A tray of food was placed in front of resident #44, two full sized corn dogs were in a bowl, not sliced. Resident #44 picked up one of the corn dogs and began hitting her left cheek with the corn dog. She then became very vocal, placed the corn dog on the meal tray, and got up. Resident #44 then wandered out of the dining area and up and down the halls of the secured unit. She was very vocal, repeating the same words over and over, and laughing. She returned to the table containing her meal tray multiple times through the dining observation. She did not take a bite of the corn dog, and did not eat any of the food from the tray. Staff member M tried multiple times, without success, to redirect resident #44 back to the table and to eat her meal. During an interview on 9/13/22 at 12:59 p.m., staff member M said resident #44 would wander through the unit while she ate. Staff member M had tried to have resident #44 sit at a table in the dining room to eat, and resident #44 would not stay seated to eat. During an interview on 9/13/22 at 2:07 p.m., staff member F stated resident #44 would wander through the secured unit while she ate. Staff member F said resident #44 was to have her foods cut and placed in a bowl so she could carry her food while wandering in the unit. Food was to be cut up by dietary and sent up to the unit for the resident. During an interview on 9/14/22 at 11:18 a.m., staff member I said the dietician had not make it up to the secured unit recently. Staff member I said she was not aware of any dietary supplements ordered for resident #44 and if she liked things, she would eat them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/14/22 at 2:39 p.m., staff member G stated resident #44's weight loss was identified in August 2022, and it was being discussed. Staff member G said resident #44 was not on any supplements and the POA was contacted. The facility had not heard back from the POA. Staff member G said nutritional assessments should be done quarterly and annually. He would then do a word document that was submitted to the EMR. If a concern was identified, a significant change would be done in the MDS. Staff member G stated, MDS is a mess here. When we had a coordinator, they would give me a list and I would do section K. Staff member G said he would generate a weight summary report weekly from the EMR, and there would be a meeting to discuss residents at risk for weight loss. Nursing would notify the physician and put in any orders for supplements. Record review of resident #44's weight chart, showed the resident weighted 117.8 pounds on 6/21/22 and 108.2 pounds on 9/12/22. This was a 9.6-pound weight loss which resulted in a 8.15% weight loss. Supplemental addition of ensure with meals was initiated on 9/14/22. A request was made for resident #44's physician notification and physician notes on 9/12/22 and 9/14/22. No documentation was provided by the facility by the end of the survey. 4. Record review of a facility document, ED Provider Notes, dated 7/26/22, showed resident #79 was seen and evaluated in the ER for rectal bleeding. Record review of resident #79's nurses note, dated 7/26/22, showed, Resident sent back from the hospital. Wife POA decided not to do anything about bleeding and resident was sent back from hospital. Will continue to monitor. A request was made on 9/13/22 for resident #79's monitoring notes for his rectal bleeding. No notes were provided by the facility by the end of the survey. Record review of resident #79's blood pressures, showed resident #79 had multiple days of low blood pressure readings following his diagnosis of rectal bleeding, with the lowest reading of 85/50 on 9/5/22. No documentation of additional monitoring, no documentation of physician notification, or additional interventions were found in the resident's EMR. Record review of resident #79's care plan, initiation date 1/10/22, bowel and bladder were not addressed. Monitoring for rectal bleeding was not addressed in the care plan. During an interview on 9/13/22 at 1:42 p.m., staff member F said no record of follow-up monitoring for resident #79 was found. Staff member F said resident #79 should have been monitored for the rectal bleeding and any changes should have been reported to the physician. 5. During an observation on 9/12/22 at 11:23 a.m., resident #48 was wandering up and down the hall in the secured unit. Resident #48 had a kerlix dressing wrapped around her right ankle. The resident was complaining of pain and warmth to her ankle, and was looking for someone to help her. Staff member L was found by staff member M and came to assist resident #48. Staff member L donned gloves and checked resident #48's dressing to see if it was intact. Resident #48 was complaining of pain. Staff member L asked if she would like anything for the pain. Resident #48 declined any pain medication. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/14/22 at 12:33 p.m., staff member J stated resident #48's leg wound was present on admission. The order was to rinse the wound and change the dressing every three days, or as needed, with xeroform and kerlix. Staff member J said the wound had gotten better, but was now angry again, and the doctor had put resident #48 on Keflex. Staff member J said the wound had not been cultured to her knowledge. Resident #48 was admitted on [DATE]. During an observation and interview on 9/14/22 at 1:38 p.m., staff member J changed the dressing on resident #48's right lower calf. The soiled dressing was removed, and the wound was rinsed with saline. The wound was estimated to be approximately 1.5 inches in diameter with an inflamed and reddened area around the wound. Resident #48 was complaining of pain but declined pain medication. Staff member J stated the resident should be sent to the wound clinic and did not know why it had not been done. Staff member J said no wound education on wound evaluation and treatment had been provided by the facility. Staff member J said she had not always been good about documenting because she got busy with other residents. During an interview on 9/14/22 at 1:58 p.m., staff member B said the secured unit was opened in April 2022. The facility had identified an issue with the assessment and implementation process. The facility had been working to implement the new process, but had difficulties due to staffing. Record review of resident #48's Admission MDS, with an ARD of 8/8/22, showed, In Progress. The Admission MDS had not been completed. The Medicare five-day assessment dated [DATE], showed, In Progress, and the end of part A stay dated 9/1/22 showed, In Progress. Record review of resident #48's care plan, showed focus area of chronic venous status ulcer to right calf was added on 9/12/22, after a request for documentation was made by the State Survey Agency. Review of a facility document titled, Wound Care, dated October 2010, showed: . Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. No wound documentation was found in the facility's EMR or was provided by the facility for resident #48. During an interview on 9/12/22 at 1:21 p.m., staff member F said no one had been onsite to do MDSs since February of 2022. Staff member F said the facility did not have an MDS coordinator. Staff member F said the MDS coordinator would also initiate and revise resident care plans. During an interview on 9/13/22 at 9:46 a.m., staff member B said the completion of MDS assessments and care plans were identified as a concern in February (2022), but staffing had been an issue. Staff member B said the facility had not been able to keep an MDS coordinator on staff. Staff member B said the MDS should be used to identify care concerns for residents. Staff member B said part of an admission, annual, or significant change MDS was the completion of the CAAs (care area assessments), and this would assist in generating a person-centered care plan.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45448 Based on observation, interview, and record review, the facility failed to initiate interventions for monitoring of residents with witnessed inappropriate touching for 2 (#'s 44 and 47) of 2 sampled residents. Findings include: Record review showed, on 8/17/22 at 11:30 a.m., staff member H witnessed resident #43 with his hand in resident #47's groin area rubbing her. Resident #43 was redirected by staff member H. Record review showed, on 8/17/22 at 11:30 a.m., staff member O witnessed resident #43 attempting to rub body against female resident (#44) while touching her buttocks. Staff member O informed resident #43 he was not allowed to touch other residents. Resident #43 pulled his hands away, stepped back, and stated, I didn't know I wasn't allowed to do that. Review of resident #43's nursing note by staff member O, dated 8/17/22 at 11:34 a.m., showed, Resident redirected for touching female resident's breast. He was easily redirected. Review of a facility reported incident, dated 8/17/22, showed the facility placed resident #43 on 1 - 1 supervision. During an interview on 9/13/22 at 1:25 p.m., staff member L stated she was unaware of any inappropriate behavior for resident #43, and it was another resident that was involved in the incident for residents #44 and #47. Staff member L said the secured unit was documenting 15-minute checks on another resident but not on resident #43. During an interview on 9/13/22 at 2:07 p.m., staff member F stated it was resident #43 that had been involved in the inappropriate touching, and she was unaware of any other residents being monitored. Staff member F said she would go talk to the staff, and it had been care planned for resident #43 to have 1:1 monitoring. During an interview on 9/14/22 at 8:14 a.m., staff member F stated no monitoring had occurred for resident #43 since the incident. Staff member F said, There was some confusion as to the resident requiring 15-minute checks. I have talked to the staff, and they will start today. During an interview on 9/14/22 at 1:58 p.m., staff member B said the behavior for resident #43 was not typical. Staff member B said, We believe it is blown out of proportion. We had a reenactment done and it was determined not to be abuse. Staff member B said resident #44 will often get into other resident's personal space and the facility felt it was not an issue. Staff member B said, 1:1 monitoring is one staff to one resident; she does not know why that was the plan in place because the facility decided to do 15-minute checks on resident #43. Record review of resident #43's care plan, revision date 8/25/22, showed: . Focus Resident is at risk for abuse d/t history of altercations and incidence of touching peers . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Interventions . . Monitor (resident #43's) whereabouts on the memory care unit- redirect as needed away from peers as needed to maintain safety Date Initiated 8/25/22 . Record review of a facility document titled, Abuse Prevention Program, dated December 2016, showed: . Sexual Abuse is non-consensual contact of any type with a resident.