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	07/21/2021

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 33796 Based on observation and interview, the facility failed to provide a clean pillow and shirt for 2 days for 1 (#5) of 4 sampled residents. Findings include: During an observation on 7/19/21 at 8:00 a.m., resident #5 was lying on a bloody pillow with no pillow case and wearing a shirt with a bloody stain. During an interview on 7/19/21 at 9:17 a.m., resident #5 stated the pillow was pretty nasty and should be thrown away. During an interview on 7/19/21 at 12:00 p.m., staff member M stated she would provide new linens for resident #5 after the lunch room tray pass. During an observation and interview on 7/20/21 at 7:59 a.m., the bloody pillow was still on resident #5's bed. The resident continued to wear the shirt with the bloody stain. Staff member M stated there were not enough linens and she would need to wait for clean laundry. During an interview and observation on 7/20/21 at 9:55 a.m., staff member C was shown resident #5's bloody pillow and stated she would throw it away. During an observation on 7/20/21 at 2:21 p.m., resident was lying in bed without a pillow.

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

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

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 44769 Based on observation and interview, the facility failed to post in a place readily accessible to residents, family members, and legal representatives of residents, the results of the most recent survey of the facility. This had the potential to affect all the residents who reside in the facility. Findings include: During an interview on 7/20/21 at 8:12 a.m., Staff member B stated she had the State survey results in her office. During the group meeting on 7/20/21 at 8:34 a.m., all residents in attendance, #s 7, 9, 18, 34, and 36, stated they did not know where the State survey results were located. During an observation on 7/20/21 at 8:55 a.m., the State survey results could not be located, in any areas accessible to residents.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41884 Based on interview and record review, the facility failed to ensure a resident's correct advance directives and code status were in place and documented according to the resident's wishes, creating the potential for the wrong treatment to be given in the event of an emergency for 2 (#'s 2 and 192) of 4 sampled residents. Findings include: 1. Record review of resident #192's POLST in the medical record in PCC, dated [DATE], showed DNR. Resident #192's code status in the PCC Profile tab showed Full Code. During an interview on [DATE] at 9:06 a.m., staff member L stated if resident #192 was found unresponsive, she would check the resident's respirations and pulse and yell out for a CNA. Staff member L stated, I have codes written on my sheet, but I don't have hers, she is full code, it states full code on PCC, I go strictly from PCC for code status. During an interview on [DATE] at 9:10 a.m., staff member D stated, If a resident was found unresponsive, I would try to arouse the resident and if still unresponsive, I would call the doctor and call the family, and check the DNR status on the computer. During an interview on [DATE] at 9:14 a.m., staff member B stated, Staff member E gets the POLST when admitting new residents; the admitting nurse, usually the DON, puts the code status in PCC, usually found on the orders from the hospital where the code status is included; we also get our own code status, and the resident signs, and the doctor and social worker signs. Review of the facility's policy titled, Advance Directives, dated [DATE], showed: . 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. . 10. The plan of care for each resident will be consistent with his or her documented reatment preferences and/or advance directive. . 20. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. 41951 2. During an interview and record review on [DATE] at 8:27 a.m., staff member C was asked if the POLST (Physician Orders for Life-Sustaining Treatment) for resident #2 was located somewhere other than in the chart. Staff member C was unable to locate the POLST, and notified staff member E. No advance directives were located in the electronic record or hard copy chart. A POLST was in the hard chart, but the document was blank. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of resident #2's electronic record, on [DATE] at 8:29 a.m., showed the code status as Full Code. During an interview on [DATE] at 9:04 a.m., staff member E stated all the resident files were just audited, and did not know what happened to resident #2's POLST or advance directives. During an interview on [DATE] at 9:06 a.m., staff member C stated if resident #2 had an emergency that required CPR (Cardiopulmonary Resuscitation), she would look it up in PCC (Point Click Care), which would have taken longer than looking in the hard chart. Staff member C stated she would have started CPR until she knew the code status and It is better to be safe than sorry.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 27820 Based on observation and interview, the facility failed to protect residents from abuse by staff members for 1 (#10) of 18 sampled residents. This failure caused ongoing feelings of resident #10 being scared and had the potential to affect all residents residing in the facility. Findings include: During an observation on 7/19/21 at 9:04 a.m., in the hall across from the nursing station, resident #10 told staff member E that she had been mistreated on Friday, 7/16/21, and forced to stay in bed. She stated she had woke up and wanted to get out of bed, and staff members G and O told her no. Staff members G and O said she had to stay in her bed and that she was not going to get any dinner. Staff member E told resident #10 he would fill out a grievance and inform staff member B. During an interview on 7/19/21 at 1:32 p.m., resident #10 stated staff members G and O told her they were not going to get her up after her nap and they were not going to bring her supper. Resident #10 said she was scared and she had called her son, and told him about this when it happened. Resident #10 stated her son had to call the facility in order for her to get supper. During an interview and observation on 7/20/21 at 7:30 a.m., resident #10 was sitting in the hall across from the nursing station. Resident #10 stated staff members G and O were there and she was scared. She stated staff members E and B had not talked to her yet. During an interview on 7/20/21 at 8:15 a.m., staff member B stated resident #10 told her yesterday about the incident. She stated resident #10 told her the two staff members would not let her get up. Staff member B stated she was going to talk with staff members G and O that day as they had not been on shift. She stated the facility had not started the investigation. During an observation on 7/20/21 at 8:24 a.m., resident #10 was sitting in the dining room finishing her breakfast. Staff member O was in the same dining room assisting another resident with her meal. During an interview on 7/20/21 at 8:28 a.m., resident #10 stated she was afraid that staff members G and O were going to retaliate against her because she had said she had been mistreated. The facility failed to protect resident #10 from alleged abuse. The facility was notified of the allegation on 7/19/21 at 9:04 a.m., and failed to act on the allegation. The facility allowed staff members G and O to work with resident #10 on 7/20/21, without an investigation or interviewing resident #10 or other residents on the unit about abuse. Resident #10 continued to voice to the surveyor that she was scared.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 27820 Based on observation, interview, and record review, the facility failed to implement the facility's policy to protect 1 (#10) of 18 sampled residents from abuse. This deficient practice had the potential to affect all residents residing in the facility. Findings include: The facility staff failed to report the incident to the Administrator, failed to immediately start an investigation, and failed to immediately place the two staff members on suspension pending an investigation. During an observation on 7/19/21 at 9:04 a.m., in the hall across from the nursing station, resident #10 told staff member E that she was mistreated on Friday, 7/16/21, and forced to stay in bed by staff members G and O. Staff member E told resident #10 he would fill out a grievance and inform staff member B. During an interview and observation on 7/20/21 at 7:30 a.m., resident #10 was sitting in the hall across from the nursing station and said staff member G and O were working today. Resident #10 stated staff members E and B had not talked to her yet. During an interview on 7/20/21 at 8:15 a.m., staff member B stated resident #10 told her yesterday about the incident. She stated resident #10 told her the two staff members, G and O, wouldn't let her get up. She stated she was going to talk with staff members G and O as they were not on shift on 7/19/21. Staff member B stated the investigation for the incident reported on 7/19/21 had not been started. During an observation on 7/20/21 at 8:24 a.m., resident #10 was sitting in the dining room finishing her breakfast. Staff member O was observed in the same dining room assisting another resident with her meal. During an interview on 7/20/21 at 9:57 a.m., staff member E stated he would usually tell staff member A about allegations in the morning meeting. He stated if the allegation was more severe, he would tell staff member A right away. Staff member E stated resident #10 did this a lot. Staff member E stated resident #10 gets upset and would misinterpret things. Staff member E stated he did not believe this allegation should be reported to the State Agency. Staff member E stated that staff member A is the person who reports allegations to the State Agency. Review of the facility policy for Abuse under the Reporting Abuse section, showed . All employees of this facility must immediately report any suspected, observed or reported incident of resident neglect, abuse, misappropriation of resident property, whether by staff members, family members or any other persons to the facility Administrator . Documentation under the ABUSE BY FACILITY EMPLOYEES section showed . When an employee of the facility abuses or is suspected of abuse of a resident, the employee is placed on immediate suspension while the matter is under investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 27820 Based on interview and record review, the facility failed to report allegations of abuse or mistreatment, and the results of all investigations to the State Survey Agency Database for 2 (#s 10 and #27) of 18 sampled residents. The deficient practice had the potential to affect all residents residing in the facility. Findings include: 1. During an interview on 7/20/21 at 8:15 a.m., staff member B stated resident #10 told her yesterday about an incident of abuse with staff members G and O on 7/16/21. Staff member B stated she was going to talk with staff member G and O, but they were not on shift on 7/19/21. Staff member B did not contact staff members G and O on 7/19/21. Staff member B stated resident #10 had a protective order against a family member, but also talks with him. The facility provided a report, dated 3/15/21, regarding an allegation of abuse by a family member, for resident #10. The report was from Adult Protective Services. The allegation had not been reported to the State Agency and was not in the State Agency Database. No protective order for visitors was provided by the facility for resident #10. 44769 2. Review of resident #27's chart showed a MD Fax Notification dated, 5/7/21, under Nurse's Note with FYI: (wrote above it), Thinks another resident is stealing all his jeans clothes. (staff checked and this is not the case) Knocked on residents door stating you know what this is about. Open this door. Other resident walked to nurses station with resident (#27) behind him calling him profane names Pu**y threatening to kick his a** Monitoring situation closely! [sic]. During an interview on 7/19/21 at 3:05 p.m., staff member B stated, we were told by the NF2 that we did not have to report a Facility Reported incident (FRI), if there was no physical touch between residents. There was no documentation in the State Agency's Database reporting system for this incident.

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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. 27820 Based on observation and interview, the facility failed to promptly investigate, prevent, and correct all allegations of abuse for 1 (#10) of 18 sampled residents. This deficient practice had the potential to affect all residents residing in the facility. Findings include: During an observation on 7/19/21 at 9:04 a.m., in the hall across from the nursing station, resident #10 told staff member E that she had been mistreated on Friday, 7/16/21, and forced to stay in bed by staff members G and O. Staff member E told resident #10 he would fill out a grievance and inform staff member B. Staff member E did not say when the grievance would be filed or when he would notify staff member B. During an interview on 7/19/21 at 1:32 p.m., resident #10 stated she was scared of staff members G and O, and had called her son about the incident on 7/16/21, when it happened. Resident #10 stated her son had to call the facility in order for her to get supper. During an interview and observation on 7/20/21 at 7:30 a.m., resident #10 was sitting in the hall across from the nursing station. Resident #10 stated staff members G and O were working, and she was scared. She stated staff members E and B had not talked to her yet. During an interview on 7/20/21 at 8:15 a.m., staff member B stated resident #10 told her yesterday about the incident. Staff member B stated the facility had not started the investigation. She stated resident #10 told her the two staff members would not let her get up. Staff member B stated she was unable to talk with staff members G and O on 7/19/21, as they had not worked that day. During an observation on 7/20/21 at 8:24 a.m., resident #10 was sitting in the dining room finishing her breakfast. Staff member O was in the same dining room assisting another resident with her meal. During an interview on 7/20/21 at 8:28 a.m., resident #10 stated she was afraid that staff members G and O would retaliate against her because she reported being mistreated. The facility failed to investigate, prevent, and correct all allegations of abuse for resident #10. The facility was notified of an allegation of abuse on 3/15/21 and on 7/19/21 at 9:04 a.m The facility did not start an investigation about the incident on 3/15/21, or the incident reported on 7/19/21 until 7/20/21.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41884 Based on interview and record review, the facility failed to ensure a resident's care plan reflected the documentation of the correct Advance Directives, creating the potential for the wrong treatment to be given in the event of an emergency for 1 (#9) of 1 sampled resident; and failed to update and revise care plans to reflect the mood, discharge plan, and behaviors for 2 (#s 4 and 29) of 4 sampled residents. Findings include: 1. During a record review on [DATE] at 9:33 a.m., resident #9's care plan dated [DATE] showed two conflicting focus areas for the resident's code status as shown by, [resident #9] has elected Code Status DNR, Date initiated: [DATE], Target Date: [DATE]; [resident #9] has an Advance Directive as evidenced by Full Code (CPR), Date Initiated [DATE], Target Date: [DATE]. During a record review on [DATE] at 9:35 a.m., the POLST document copy on file in resident #9's medical record in PCC, was dated [DATE], showed Attempt CPR with Limited Additional Interventions. Resident #9's code status in the PCC Profile tab showed Full Code. During an interview on [DATE] at 9:14 a.m., staff member B stated, We use a computer program called IDT Person Centered Baseline Care Plans, that makes a basic care plan and MDS makes changes to fit the person. Staff member B stated, The MDS person and DON monitor to make sure everyone does their part in the care plan. Staff member B stated, For the DNR status, staff member E gets the POLST when admitting new residents; the admitting nurse, usually the DON, puts the code status in PCC, usually found on the orders from the hospital where the code status is included; we also get our own code status, and the resident signs, and the doctor and social worker signs. Review of the facility's policy titled, Using the Care Plan dated [DATE] showed: Policy Statement - The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. 6. Documentation must be consistent with the resident's care plan. Review of the facility's policy titled, Advance Directives dated [DATE] showed: . 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. . 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. . 20. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. 33796 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation and interview on [DATE] at 12:02 p.m., resident #4 stated she doesn't care anymore. I'm not going home, I'm dying here, and I've lost my comfort zone. I miss my dog so much, and he will die soon. Resident #4 began to cry. She stated she just looks out the window and cries. I don't like feeling this way, and I cry a lot. The nurses ask me why I cry. Review of resident #4's care plan showed Resident Adjustment to SNF [resident #4] admitted for Short term stay, [resident #4] requires assist making adjustment to SNF placement, Unknown length of stay Date Initiated: [DATE] Revision on: [DATE] [Resident #4] uses antidepressant medication r/t mood/Depression Date Initiated: [DATE] Revision on: [DATE] Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement, agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance Date Initiated: [DATE] Revision on: [DATE] Review of resident #4's Social Service note, dated [DATE], showed the resident did want to go home. Staff member E stated he had a referral packet ready and was just waiting for discharge orders. Review of resident #4's Social Service note, dated [DATE]. showed resident #4 was looking at discharging in a couple of weeks. During an interview on [DATE] at 8:20 a.m., staff member L stated resident #4 was very depressed since she found out she was not going home. Review of resident #4's Electronic Record showed no other social service notes regarding the change in discharge or the resident's depressed mood. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During at interview on [DATE] at 9:09 a.m., staff member E stated resident #4 might be sad, but she had not talked to him about her mood. He stated he would usually update the care plan, but nothing had triggered from the admission MDS. Review of resident #4's care plan did not include her significant depression or current discharge plans, with interventions and support. 3. During an interview on [DATE] at 8:05 a.m., resident #29 stated his name loudly and said, What do you want? During an interview on [DATE] at 8:22 a.m., staff member L stated resident #29 could be pretty rough and hard to satisfy. He is very quick to anger and his automatic response is to yell. He can definately be crabby and does yell at people. During an interview on [DATE] at 9:29 a.m., staff member I stated resident #29 was awful. He is downright mean and verbally abusive to the staff. She stated he called her a 'crazy bitch' for not getting his wheelchair unlocked quick enough. She stated the intervention she used was to just walk away. Review of resident #29's care plan, dated [DATE], did not include a concern or interventions for mood and behaviors. During an interview on [DATE] at 9:35 a.m., staff member E stated resident #29 can get angry if he has to wait, but other than that the resident was fine. During an interview on [DATE] at 10:02 a.m., staff member NF3 stated the care plan system was broken, and the facility was aware the care plans were not being updated and revised.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44769 Based on record review and interview, the facility failed to implement an effective discharge planning process or document a refusal for 1 (#43) of 1 supplemental resident, who left the facility Against Medical Advice. Findings include: During an interview on 7/19/21 at 4:17 p.m., staff member B stated resident #43 came to the facility the morning of 4/29/21, and left AMA (Against Medical Advice) that same afternoon. Staff member B stated she couldn't find documentation of resident refusal in the electronic record, and would track down the hard chart. A review of resident #43's medical record showed an admitted [DATE], and failed to show discharge paperwork, or resident refusal or discharge documentation. During an interview on 7/20/21 at 8:24 a.m., staff member B stated they have no AMA paperwork or a refusal documented for resident #43. They have AMA paperwork, I don't know why they didn't fill it out for him. Review of the facility policy titled, Discharging a Resident without a Physician's Approval undated, showed . 3. If the resident or resident representative (sponsor) insist upon being discharged without the approval of the attending physician, the resident and/or representative (sponsor) must sign a release of responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33796 Based on observation, interview, and record review, the facility failed to identify and provide treatment for open sores for 1 (#5) of 4 sampled residents. Findings include: During an observation and interview on 7/19/21 at 4:21 p.m., resident #5 was in bed lying on a bloody pillow. He stated he had sores on his back, and they itched and hurt. He stated he didn't know what they were. He pulled up his shirt and he had 7 dime-sized sores on his upper back. He stated the nursing staff did not put any cream on them. Review of resident #5's Physician Orders, dated 5/21/21, showed an order for [NAME] butt paste to reddened buttocks twice a day. The physician orders did not include a treatment for the sores on his back. During an interview on 7/20/21 at 8:20 a.m., staff member L stated she was putting the butt paste on resident #5's sores. She stated he did not receive anything for the itching, but she would contact the physician. During an interview on 7/20/21 at 11:40 a.m., staff member C said resident #5 picks at the sores, and it was a nervous habit of his. During an interview on 7/20/21 at 4:01 p.m., staff member L stated she was following Physician Orders, and putting the butt paste only around resident #5's buttocks. Review of resident #5's skin assessment, dated 7/6/21, showed arms with self-inflicted scabs and scratches. Review of resident #5's skin assessment, dated 7/16/21, showed scabbed sores to the right and left buttock, with no description. The open sores on resident #5's upper back were not identified. Review of resident #5's physician visit note, dated 4/21/21 and 4/28/21, did not identify any skin concerns.

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	275103	A. Building B. Wing	07/21/2021

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41951 Based on observation, interview, and record review, the facility failed to ensure residents at risk for choking were monitored by staff, in the C-wing dining room for 1 (#2) and the A-wing dining room for 5 (#s 9, 27, 33, 36, and 196) of 8 sampled and supplemental residents; and failed to use a gait belt for transfers for 1 (#26) of 1 supplemental resident. Findings include: 1. During an observation on 7/18/21 at 12:19 p.m., staff member I entered the dining room on the C wing and served resident #2 his meal, then left the area. During an observation on 7/18/21 at 12:26 p.m., resident #2 was coughing, and no staff were in the dining room. During an observation on 7/18/21 at 12:27 p.m., staff member P entered the C wing dining room and resident #2 stated, I choked and was still coughing. Staff member P placed a clothing protector on resident #2 and continued to talk to him. Staff member P left the dining room to get more coffee for residents. During an observation on 7/18/21 at 12:29 p.m., staff member P returned to the dining room and resident #2 was still coughing. Staff member P asked resident #2 to cover his mouth when coughing, then left the dining room. During an observation on 7/19/21 at 8:01 a.m., resident #2 was eating his breakfast and no staff were in the dining room. During an observation on 7/19/21 at 8:08 a.m., resident #2 was coughing while eating his meal. Resident #2 cleared his throat and continued to eat. During an interview on 7/20/21 at 7:39 a.m., resident #2 stated, Sometimes staff are in the dining room, but not often. During an observation on 7/20/21 at 8:09 a.m. resident #2 was served his breakfast tray and no staff remained in the dining room. During an observation on 7/20/21 at 8:20 a.m., resident #2 was coughing and no staff were present in the dining room. No staff were visible outside of the dining room or at the nurses station, which was approximately 20 feet away from the dining room door. During an interview on 7/20/21 at 8:26 a.m., staff member G stated usually there is a staff member in the dining room to monitor residents at risk for choking, but we were passing trays to other residents. Staff member G stated staff would hear a resident if they were choking. Review of resident #2's Quarterly MDS, with an ARD of 4/17/21, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Section I: Cerebrovascular Accident, Hemiplegia and Hemiparesis, Traumatic Brain Injury, and Dysphagia. Review of resident #2's Nutritional Assessment, dated 7/7/21, showed: - Diet Texture: National Dysphagia 2 (Mechanical Soft), - Thickened Liquids: Nectar Thick, and - Summary: .He is supervised at meals, to be monitored for pocketing at end of meals . Resident #2 had received the correct diet textures for the observed meals. Review of resident #2"s care plan, initiated 3/24/21, showed: - .has a swallowing deficit r/t CVA and disease process. He has been choking, coughing when eating, and .Monitor for choking, encourage to take small bites . 33796 2. During an observation on 7/18/21 at 12:01 p.m., no facility staff were observed in the A-wing dining room during the lunch meal. During an observation on 7/19/21 at 7:54 a.m., no facility staff were observed in the A-wing dining room during the breakfast meal. During an interview on 7/19/21 at 1:56 p.m., staff member M stated the dining room did not have staff supervision. She said she thought it was probably related to staffing. She said she assumed none of the residents' had trouble swallowing. During an interview on 7/19/21 at 2:10 p.m., staff member N stated nursing staff supervised the A-wing dining room as they walked by, while passing room trays. During an interview on 7/20/21 at 3:57 p.m., staff member B stated there were not that many residents in the dining room to supervise, and staff should have there eyes on them. Hopefully if a resident choked the nurse would catch it. Most residents in there are 'with it', but I guess anyone could choke. A Policy and Procedure for Dining Supervision was requested on 7/20/21 and was not received. 27820 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation and interview on 7/20/21 at 7:41 a.m., staff members G and O provided care for resident #26. Staff members G and O assisted the resident in getting dressed while lying in his bed. Both staff members then assisted resident #26 to sit up on the side of his bed. Staff members G and O placed the wheel chair next to the bed and locked the brakes. Staff members G and O were on each side of resident #26. The staff members then placed their arms under resident #26's arms, grabbed ahold of his pants and stood the resident up, pivoted to his wheel chair, and assisted him to sit down in the wheel chair. Staff members G and O did not use a gait belt for safety to assist them with the transfer of resident #26 from the bed to the wheel chair. Staff member O stated no one on the unit uses a gait belt to transfer. She stated most of the residents are a one person assist or hoyer lift.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44769 Based on observation, interview, and record review, the facility failed to ensure respiratory care was consistent with professional standards of practice for 2 (#s 39 and 292) of 7 sampled residents. Findings include: During an observation on 7/19/21 at 8:46 a.m., no labeling was found on resident #39's oxygen (O2) tubing or humidification bottle connected to the oxygen concentrator. During an observation on 7/19/21 at 8:48 a.m., no labeling was found on resident #292's O2 tubing, or humidification bottle connected to the oxygen concentrator. During an observation on 7/20/21 at 8:11 a.m., no labeling was found on resident #292's O2 tubing, or humidification bottle connected to the oxygen concentrator. During an observation on 7/20/21 at 8:13 a.m., no labeling was found on resident #39's O2 tubing, or humidification bottle connected to the oxygen concentrator. During an interview on 7/20/21 at 9:42 a.m., staff member I stated she was unaware of a policy for labeling oxygen tubing, and she has changed out O2 tubing, but doesn't date the tubing or document the change. During an interview on 7/20/21 at 9:46 a.m., staff member R stated night shift changes O2 tubing. During an interview on 7/21/21 at 9:34 a.m., staff member B stated O2 tubing is changed every Sunday by the night nurse. The oxygen tubing change is charted in orders, and pops up every Sunday. Staff member B was unable to find orders for oxygen tubing change for resident #'s 39 and 292 in the EMR. A review of records for resident #s 39 and 292 failed to show documentation for O2 tubing and/or humidification bottle change for July 2021. A review of a facility policy titled, Subject: Cleaning and Storage of Medication Nebulizer, mask (CPAP, BIPAP), mouth piece, tubing and machine dated 11/26/19, showed: POLICY: Cleaning and storing of Oxygen tubing, nebulizer machine, CPAP, BIPAP, Nebulizer mask and tubing. PROCEDURE: 6. Change tubing and mask or hand held device weekly. Date the tubing.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41884 Based on observation, interview, and record review, the facility failed to ensure the daily posting of staffing information had been updated each day with the required information, and failed to make the data available to the public and residents. This practice had the potential of affecting any resident and visitor wishing to view the staff posting. Findings include: During an observation and record review on 7/19/21 at 5:30 p.m., the Daily Posting of Hours of the Nurse Staffing sheet, posted outside the DON's office, had not been updated since 6/14/21, and contained only that date's report. During an observation and record review on 7/20/21 at 8:09 a.m., the Daily Posting of Hours of the Nurse Staffing sheet, posted outside the DON's office, had not been updated since 6/14/21, and contained only that date's report. During an interview on 7/20/21 at 8:12 a.m., when asked about the Daily Posting of Hours of the Nursing Staffing sheet, staff member B stated, My scheduler has been out, there's no excuse, but I'll get it out. Review of the facility policy titled Posting Direct Care Daily Staffing Numbers dated July 2016 showed: Policy Statement - Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. . 7. The previous shift's forms shall be maintained with the current shift form for a total of 24 hours of staffing information in a single location. Once a form is removed, it shall be forwarded to the Director of Nursing Services' office and filed as a permanent record.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33796 Based on interview and record review, the facility failed to evaluate and renew the continuation of an 'as needed' psychotropic medication and for an 'as needed' hypnotic every 14 days, with no documented rational in the medical record for 2 (#s 5 and 12) of 8 sampled residents. Findings include: 1. Review of resident #5's June 2021 Medication Administration Record showed the resident was ordered Ativan, an antianxiety medication, every 8 hours, as needed. Review of the Pharmacist's Note to Attending Physician, for the month of June, showed, This resident is currently receiving the following psychotropic medication on a PRN basis - Lorazapam. Per regulatory guidelines, the duration of treatment with such medication on a PRN basis should be limited to 14 days. Please evaluate the continued need for this medication. If it is to be extended, please document the rationale for this extended time period in the medical record, and indicate a specific duration. The note did not include a physician signature or recommendation. During an interview on 7/20/21 at 2:21 p.m., staff member B stated the physician must not have seen the Pharmacy recommendation yet. She stated it what probably still in his box. Staff member L checked to see if the note was in the physician's box, and stated the box had fallen off the wall, and she could not locate the note anywhere else. 27820 2. Review of resident #12's medical record showed the resident had a physician order for Temazepam capsule 15 mg every 24 hours as needed for insomnia. The order was dated 4/30/21. The medical record showed that the resident used the medication nine times in the month of 5/21, and one time in the month of 6/21. There was no evidence in the medical record that the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days. During an interview on 7/20/21 at 12:44 p.m., staff member B stated the facility policy was that antipsychotics and sleeping medications that are PRN have to be evaluated and re-ordered every 14 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44769 Based on observation, interview, and record review, the facility failed to provide separately locked, permanently affixed compartments for storage of controlled drugs, and failed to ensure expired medications were removed from the medication storage room. This deficient practice had the potential to affect any residents receiving the flu vaccine or controlled medications. Findings include: During an observation of the medication storage room on 7/19/21 at 3:22 p.m., six, 30 ml. vials of Lorazepam, 2mg/ml, were stored in an unlocked refrigerator on the shelf, and not in a locked container. The refrigerator had a padlock hasp, with no lock present. During an interview on 7/19/21 at 3:22 p.m., staff member L stated she did not know why the refrigerator was not locked, and she had questioned another staff member and they weren't sure why it wasn't locked either. During an observation of the medication storage room on 7/20/21 at 7:35 a.m., the following expired medications were found: - 7 boxes of Flucelvax Quadrivalent flu vaccine, containing ten 0.5 ml, single dose, prefilled syringes, with a manufacturer expiration date of 6/9/21. - 6 boxes of Flucelvax Quadrivalent flu vaccine, containing ten 0.5 ml, single dose, prefilled syringes, with a manufacturer expiration date of 6/30/21. - 1 box of Flucelvax Quadrivalent flu vaccine, containing three 0.5 ml, single dose, prefilled syringes, with a manufacturer expiration date of 6/30/21. - 2 boxes of Fluad Quadrivalent flu vaccine, containing ten 0.5 ml, single dose, prefilled syringes, with a manufacturer expiration date of 6/30/21. - box of Fluad Quadrivalent flu vaccine, containing five 0.5 ml, single dose, prefilled syringes, with a manufacturer expiration date of 5/4/21. During an interview on 7/20/21 at 8:21 a.m., NF1 stated the manufacturer expiration date was when the medication expires, and the pharmacy label was for tracking. During an interview on 7/20/21 at 11:38 a.m., staff member B stated refrigerated controlled medications are double locked. They are stored in a locked box inside the refrigerator that is always locked. During an interview on 7/20/21 at 12:02 p.m., staff member L stated she has been here since the middle of June and had not seen a lock on the refrigerator in the medication storage room since then. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Storage of Medications under the heading of Policy Interpretation and Implementation undated, showed: . 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. A review of a facility policy titled, Controlled Substances under the heading of Policy Interpretation and Implementation undated, showed: . 3. Controlled substances are stored in the medication room in a locked container, separate from containers for any non-controlled medications. 4. Access to controlled medications remains locked at all times and access is recorded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 41884 Based on observation, interview, and record review, the facility failed to provide effective infection control and prevention for COVID-19 precautions by failing to ensure all staff and visitors were screened prior to entering the facility, failed to ensure all staff were properly wearing PPE, and failed to ensure resident wheelchair armrests were repaired to prevent the risk of infection for 5 of (#s 7, 20, 21, 27, and 29) of 6 sampled and supplemental residents. Findings include: 1. COVID-19 Screening During an observation on 7/18/21 at 10:44 a.m., there was no signage at the facility entrance indicating the need to stop for COVID-19 precautions screening prior to entering the facility, and there was no one seated at the desk near the front entrance screening area of the facility. During an observation on 7/18/21 at 10:50 a.m., staff member R asked the survey team to complete screening documentation and took temperatures of the survey team, after being asked if she was going to screen the team, prior to their entrance to the facility. During an interview on 7/18/21 at 11:15 a.m., staff member V stated all staff enter the facility through the front entrance, and self screen themselves when they enter the facility at the start of their shift. During an observation on 7/19/21 at 7:20 a.m., there was no facility staff at the entrance to screen the survey team. Facility admissions staff asked the survey team if they were checking in and if they had the screening forms. Survey team members prompted the facility staff to sanitize the thermometer prior to checking the temperatures of the survey team. During an interview on 7/19/21 at 12:38 p.m., staff member H stated she checks herself in for COVID-19 screening when she enters the front door of the building. Staff member H stated she is unsure of who to report to if she had an elevated temperature when screening. Staff member H stated all staff are supposed to do the screening every day, but was unsure if everyone did the screening because it is not monitored. During an intervew on 7/19/21 at 1:33 p.m., staff member D stated all COVID-19 employee screening sheets went to the previous administrator. Staff member D stated she is not sure where the completed screenings are going now or who is monitoring them. During an interview on 7/19/21 at 1:51 p.m., staff member T stated he enters work through the front entrance of the facility. Staff member T stated, It looks like there's a lady out there for the first time. The lady that used to be there is having surgery. We take our own temp, wash our hands after that, and then I go to work. I always have a mask on when I come in, and I fill out a form and leave it in the binder. I think a fever is 100.3 degrees, but if I had a 100.3 temperature, I would probably let the nursing staff know and let my supervisor know. I would stay at the front entrance to make calls about the temperature. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/19/21 at 2:06 p.m., staff member U stated she takes the temperature of the employees first, and then has them wash their hands for 30 seconds. For any temperature over 100 degrees, I have to get the DON. During an observation on 7/20/21 at 7:15 a.m., no staff was at the screener desk at the facility. During an observation on 7/20/21 at 8:11 a.m, staff member U entered the facility and performed self screening and temperature check. No other staff members were present to verify the screening. During an observation on 7/21/21 at 7:15 a.m., no facility staff were at the front screening desk or at the nurses' station, and the survey team self screened themselves and left the screening paperwork on the screening desk. During an interview on 7/21/21 at 9:14 a.m., staff member B stated she and another staff member are reviewing and signing screening documents on a weekly basis, and are saving all previous screenings. Staff member B stated, We don't have any way of knowing if someone hasn't completed screening, the facility is looking at systems to print out screening armbands or badges. During an observation on 7/21/21 at 10:38 a.m., there was no signage at the front door of the facility advising all entrants to stop for COVID-19 screening prior to entering the facility. Review of the facility document titled, [facility name] COVID-19 and Respiratory Disease Screening for Indoor Visits, dated 3/17/2021, showed: Screener to Verify hand sanitization, PPE usage, temperature, onset and symptom questions for any person visiting the facility. Review of the facility document policy titled, COVID-19 Prevention Plan, showed: . I. Infection Control - Visual alerts and signs will be posted at the entrance and throughout the facility to provide residents and healthcare staff information about hand hygiene, respiratory hygiene and cough etiquette. Approved visitors will have their temperatures taken prior to entry to the facility. Temperature > 100' F will warrant no entry to the facility. Review of the facility policy titled, Infection Prevention and Control COVID-19 Policy, dated 3/16/2020, showed: . 2. Screening Employees: a. Facility will actively verify absence of fever and respiratory symtoms when employees report to work-beginning of their shift. 2. PPE Usage During an observation on 7/18/21 at 10:45 a.m., staff member Q was standing at the medication cart located at the nurse's station near the facility lobby, talking on the phone with her mask pulled down below her chin. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 7/19/21 at 9:02 a.m., resident #192 was observed passing through the facility lobby on the way out to the facility van parked in front of the facility. Resident #192 was loaded in the facility van and was not wearing a mask. Staff member S was wearing a mask and stated she would put a mask on resident #192 once resident's wheelchair was positioned in the van. During an observation on 7/19/21 at 9:09 a.m., resident #192 was observed in facility van, and was not wearing a mask. Review of the facility policy titled, Personal Protective Equipment - Using Face Masks, dated September 2010, showed: . Miscellaneous . 2. Be sure the face mask covers the nose and mouth while performing treatment or services for the patient. 4. Do not hang the face mask around the neck. Review of the facility policy titled, COVID-19 Prevention Plan, showed: . IV. Resident care - Any resident who leaves the facility for a medically necessary reason(s) will wear a face mask (if available). 3. Wheelchair Armrests During an observation on 7/19/21 at 8:03 a.m., resident #27 was seated in the dining room eating breakfast. The armrests of his wheelchair were cracked and the padding was exposed. The armrest on the left side had duct tape wrapped on part of the armrest. During an observation on 7/19/21 at 8:08 a.m., resident #20 was seated in her wheelchair near the nurses' station in the main lobby. The resident's wheelchair arms were cracked on the left side, and the right side was cracked open and the foam padding was exposed. During an observation on 7/19/21 at 8:55 a.m., resident #29's wheelchair arms were cracked and the padding was exposed. During an interview on 7/20/21 at 12:56 p.m., staff member K stated he gets a list from nursing or therapy for repairs that need to be made on the wheelchairs. Staff member K stated, It's been 6 months since I got a list, and I'm all caught up on repairs that are given to me on the yellow lists or verbal requests, and all the wheelchair armrests are repaired here. During an interview on 7/21/21 at 8:08 a.m., staff member P stated if residents' wheelchairs need repairs, the staff fills out maintenance request forms, and the facility maintenance staff fixes the wheelchairs. Staff member P stated she hadn't seen any wheelchair armrests that were torn. 41951 (continued on next page)

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	07/21/2021

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

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 - Many	During an observation on 7/19/21 at 9:00 a.m., resident #21 was in his room watching T.V., seated in his wheelchair. The vinyl on the left armrest of the wheelchair was separating at the lateral seam. During an observation on 7/19/21 at 9:15 a.m., resident #7 was seated in his wheelchair, rolling by the nurses station next to the lobby. The vinyl on the left armrest of the wheelchair was separating at the lateral seam. During an observation on 7/19/21 at 11:57 a.m., resident #27 was sitting in his wheelchair in the hall outside his room. The front of the left armrest was missing vinyl, and the lateral seam of the right armrest was separating. 44769

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	07/21/2021

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 44769 Based on observation, interview, and record review, the facility failed to provide a working call light system for residents to call for staff assistance for 2 (#s 5 and 22) of 7 sampled and supplemental residents. Findings include: During an observation on 7/18/21 at 12:48 p.m., the call light button in resident #5's room was pressed, and failed to activate the call light outside the room in the hall. During an observation on 7/18/21 at 2:04 p.m., the call light button in resident #22's room was pressed, and failed to activate the call light outside the room in the hall. During an observation on 7/19/21 at 7:56 a.m., the call light button in resident #5's room was pressed, and failed to activate the call light outside the room in the hall. During an observation on 7/19/21 at 8:02 a.m., the call light button in resident #5's room was pressed, and failed to activate the call light outside the room in the hall. During an observation on 7/20/21 at 8:08 a.m., the call light button in resident #22's room was pressed, and failed to activate the call light outside the room in the hall. During an observation on 7/20/21 at 10:37 a.m., the call light button in resident #5's room was pressed, and failed to activate the call light outside the room in the hall. During an interview on 7/20/21 at 10:41 a.m., staff member I stated she had not been instructed to check call lights. Staff member I stated residents would tell staff members when the call light was not working if they pushed it and it did not come on. During an observation on 7/21/21 at 9:12 a.m., the call light button in resident #5's room was pressed three times, and failed to activate the call light outside the room in the hall. During an interview on 7/21/21 at 10:17 a.m., staff member K stated, Call lights are checked once a month. Review of a facility record titled, Logbook Documentation, Nurse Call System Test: Conduct a test of the nurse call system, marked done on-time by staff member J, on July 21, 2021 showed, Nurse Call Checks for rooms 100-110 were marked Pass on 6/28/2021.