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

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997 Based on interview and record review, the facility failed to invite resident representatives to resident care conferences for 3 (#s 12, 22, and 49) of 3 sampled residents. Findings include: 1. During an interview on 9/14/22 at 10:33 a.m., NF2 said he had not received any invitations to any care plan meetings for resident #12. NF2 said he was in the facility at least once a week to visit resident #12, and he said staff could tell him about any care plan meetings scheduled for resident #12. NF2 said he would gladly participate in these meetings. Review of resident #12's electronic medical record (EMR) failed to show any documentation NF2 had been invited to attend care plan meetings. 2. During an interview on 9/15/22 at 10:26 a.m., NF3 said she would love to have discussed resident #22's care since the resident had been in the facility. NF3 said she had a number of concerns about the care resident #22 had been receiving, and a care plan meeting would have been the perfect place to discuss her concerns. Review of resident #22's electronic medical record (EMR) failed to show any documentation NF3 had been invited to attend care plan meetings. 45448 3. During an interview on 9/13/22 at 1:04 p.m., NF4 stated resident #49 was admitted on [DATE]. NF4 had not been asked to be involved in any care planning for resident #49. During an interview on 9/15/22 at 3:17 p.m., staff member K said there were a number of areas to address, and care plan meetings, and invitations to family was one of those areas. During an interview on 9/15/22 at 3:42 p.m., staff member B said care plan meetings had not been happening. Review of the facility's document Care Planning-Resident Participation, not dated, showed, (continued on next page)

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- . 9. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conferences at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. - 10. If the participation of the resident and/or resident representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record.

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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. 41951 Based on observation and interview, the facility failed to post the results of the most recent survey of the facility, in an area readily accessible to residents, family members, and residents' legal representatives. Findings include: During an interview on 9/12/22 at 12:28 p.m., NF5 stated the facility did not have a copy of the last survey in the lobby. NF5 stated she wanted to view the survey results to see if the facility had addressed the issues identified. During an observation on 9/12/22 at 4:10 p.m., no State Survey Agency results were in the facility lobby or near the lobby. During an interview and observation, on 9/12/22 at 4:20 p.m., staff member A stated the survey results were in the front lobby. Staff member A was unable to locate the survey results. During an interview on 9/12/22 at 4:38 p.m., staff member A confirmed there was no copy of the survey results posted in the lobby. Staff member A stated she would print a copy of the last survey and place it in the lobby.

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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. 32997 Based on interview and record review, the facility failed to maintain updated DNR (do not resuscitate) status for 3 (#s 12, 22, and 74) of 4 sampled residents. Findings include: 1. During an interview on 9/14/22 at 10:33 a.m., NF2 said the facility had never sent him a POLST (Provider Orders for Life-Sustaining Treatment) form to sign for resident #12. NF2 said he was in the facility frequently, and staff have had multiple opportunities to have him sign the POLST for resident #12. NF2 said he did remember staff asking him about resident #12's DNR status when the resident was admitted to the facility back in April (2022), and he told staff he was good with whatever was on the hospital paperwork. Review of resident #12's POLST, on the signature by patient or decision maker section showed, Voice order via phone. A signature by either the resident or the resident's representative were required for the POLST to be valid, and the resident's representative had not signed the POLST. 2. During an interview on 9/14/22 at 11:48 a.m., NF3 said she wanted resident #22 to have a DNR status. NF3 said she was not aware she needed to sign a POLST for resident #22. NF3 said the facility staff had not asked her to sign one. NF3 said she was in the facility 3to 4 times a week to visit resident #22, so she felt the facility staff had every opportunity to ask her to sign a POLST. Review of resident #22's POLST showed it had not been signed by either the resident representative or the physician. Signatures by both parties were required for the POLST to be valid. 45448 3. On 9/12/22 at 3:04 p.m., a request was made for resident #74's advance directive. The requested document was not provided by the end of the survey. During an interview on 9/15/22 at 3:17 p.m., staff member K said she had only been in her position since July 2022. Staff member K said she had identified POLSTs were not being completed several weeks ago, and she was trying to get them straightened out. Staff member K was not aware the resident or representative, and the physician both had to sign the POLST for it to be valid. Review of a facility document titled, Resident's Rights Regarding Treatment and Advance Directives, dated 5/18/22, showed: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive using the POLST form. 2. The facility will provide the resident or resident representative information, . 7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32997 Based on interview and record review, facility staff neglected to notify the physician of severe weight loss for 2 (#s 73 and 78) of 5 sampled residents; and failed to notify resident representatives of changes in conditions for 2 (#s 12 and 22) of 2 sampled residents. Findings include: 1. Review of resident #73's monthly weight record in the EMR, from 1/2022 to 6/2022, showed, the resident had a severe weight loss of 40 pounds or 19.7%. Review of resident #73's nursing progress notes, dated 1/3/22 to 9/14/22, showed facility staff neglected to notify the resident's physician of the severe weight loss for resident #73. 2. Review of resident #78's monthly weight record in the EMR, from 5/2022 to 6/2022, showed the resident had a severe weight loss of 14 pounds or 6.74%. Review of resident #78's nursing progress notes, dated 6/23/22 to 9/14/22, showed facility staff had neglected to notify the the resident's physician of the severe weight loss for resident #78. 3. During an interview on 9/14/22 at 11:48 a.m., NF3 said facility staff did not call her if resident #22 had any problems. NF3 said facility staff talk to resident #22 about her care. NF3 said due to resident #22's late effects from a cerebral aneurysm, the resident did not understand what was going on. NF3 said resident #22 would frequently refuse to do things when asked, but she said it was because the resident did not understand. NF3 said she was resident #22's power of attorney for a reason, and facility staff needed to understand that. NF3 said the resident had an MRI (magnetic resonance imaging) of her brain to see if resident #22 had any changes to her brain several weeks ago. NF3 said she had heard nothing from staff at the facility, or the resident's physician, so she hoped everything was fine. NF3 said she was in the facility 3 to 4 times a week, so it was not like staff had to take extra time to call her. NF3 said she did not understand why communication was such a problem. 4. During an interview on 9/14/22 at 10:33 a.m., NF2 said facility staff tells me nothing about resident #12. NF2 said facility staff had notified him when there was COVID-19 in the building, but that was all. NF2 said if he was not in the building every week to visit with resident #12, he would not know anything. During an interview on 9/14/22 at 1:58 p.m., staff member B said the facility IDT (interdisciplinary team) had identified several areas which needed improvement. Staff member B said facility staff were working on communication concerns with family and resident representatives. Review of a facility document titled, Change in a Resident's Condition or Status, revised April 2022, showed: - 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . d. significant change in the resident's physical/emotional/mental conditions; . - 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychosocial status; .

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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. 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, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- 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. 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. (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 2:38 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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	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	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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	275103	A. Building B. Wing	09/16/2022

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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.

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	275103	A. Building B. Wing	09/16/2022

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 32997 Based on interview and record review, facility staff failed to provide pertinent information to the receiving facility for 1 (#20) of 3 sampled residents, at the time of transfer, from the facility. Findings include: Review of resident #20's nursing progress notes, dated 8/25/22 to 9/1/22, showed the resident was transferred to a hospital for an emergent situation. The progress notes showed the hospital contacted the facility after resident #20's admission to the hospital, and requested all resident #20's medication information. Review of resident #20's EMR failed to show facility staff had sent medical information with the resident. During an interview on 9/15/22 at 3:46 p.m., staff member J said when a resident had to go to the hospital or a doctor appointment there was specific paperwork that needed to go with the resident. Those documents included the most current medication and treatment information for the resident.

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	275103	A. Building B. Wing	09/16/2022

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 32997 Based on interview and record review, facility staff failed to provide a Notice of Transfer/Discharge to the resident or resident's representative, for 1 (#20) of 3 sampled residents. Findings include: Review of resident #20's closed electronic medical record failed to show a Notice of Transfer/Discharge had been provided to the resident or a family member, at the time the resident was transferred to a hospital on 9/1/22. On 9/13/22 at 1:43 p.m., a request was made for a copy of resident #20's Notice of Transfer/Discharge for the 9/1/22 transfer. During an interview on 9/14/22 at 7:59 a.m., staff member F said a Notice of Transfer/Discharge was not provided to resident #20 or a family member.

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	275103	A. Building B. Wing	09/16/2022

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 32997 Based on interview and record review, facility staff failed to provide a Notice of Bed Hold to a resident or resident's representative, for 1 (#20) of 3 sampled residents. Findings include: Review of resident #20's closed electronic medical record failed to show a notice of bed hold had been provided to the resident or a family member, on 9/1/22, at the time the resident was transferred to a hospital. On 9/13/22 at 1:43 p.m., a request was made for a copy of resident #20's Notice of Bedhold. During an interview on 9/14/22 at 7:59 a.m., staff member F said a Notice of Bedhold had not been provided to resident #20 or a family member.

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	275103	A. Building B. Wing	09/16/2022

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997 Based on interview and record review, facility staff failed to complete accurate, timely, comprehensive Admission, Annual, or Significant Change assessments for 13 (#s 1, 5, 20, 23, 34, 42, 47, 48, 73, 77, 78, 79, and 80) of 14 sampled residents. This deficient practice led to resident neglect (refer to F600 - Neglect of Care) due to the facility's staff not identifying resident significant changes in care areas for residents and then implementing care plans for ongoing services. Findings include: During an interview on 9/12/22 at 1:21 p.m., staff member F said no one had been onsite to do MDSs (Minimum Data Set) since February of 2022. 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, and 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. 1. Review of resident #73's MDS submissions showed: - Admission MDS, dated [DATE], In Progress. This meant the assessment had not been completed or transmitted timely, and per CMS regulatory requirements. Review of the current Minimum Data Set 3.0 Manual, shows: .the primary purpose as an assessment tool is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents. Section 1.4 shows the MDS is used for the following: a. Assessment-Taking stock of all observations, information, and knowledge about a resident from all available sources . b. Decision Making-Determining with the resident (resident ' s family and/or guardian or other legally authorized representative), the resident ' s physician and the interdisciplinary team, the severity, functional impact, and scope of a resident ' s clinical issues and needs. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident ' s diagnoses and co-morbidities, and the careful consideration of the triggered areas in the CAA process. Understanding the causes and relationships between a resident ' s clinical issues and needs and discovering the whats and whys of the resident ' s clinical issues and needs; finding out who the resident is and consideration for incorporating his or her needs, interests, and lifestyle choices into the delivery of care, is key to this step of the process. (continued on next page)

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	275103	A. Building B. Wing	09/16/2022

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. Identification of Outcomes-Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting the resident ' s active participation in the process. d. Care Planning-Establishing a course of action with input from the resident (resident ' s family and/or guardian or other legally authorized representative), resident ' s physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the how of resident care. e. Implementation-Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident ' s care goals and approaches; carrying out the how and when of resident care. f. Evaluation-Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident ' s status, goals, or improvement or decline. 2. Review of resident #78's MDS submissions showed: - Admission MDS, dated [DATE], In Progress. 3. Review of resident #77's MDS submissions showed: - Admission MDS, dated [DATE], In Progress. 4. Review of resident #20's MDS submissions showed: - Annual MDS, dated [DATE], In Progress. 5. Review of resident #5's MDS submissions showed: - Entry, dated 3/23/22, - discharge date d 4/3/22, In Progress, and - discharge date d 4/21/22, In Progress. Facility staff failed to complete a comprehensive assessment prior to resident #5's discharge, on 4/21/22, from the facility. 6. Review of resident #1's MDS submissions showed: - Admission MDS, dated [DATE], In Progress. 41951 (continued on next page)

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	275103	A. Building B. Wing	09/16/2022

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Review of resident #23's MDS submissions showed: - Annual MDS, dated [DATE], In Progress. 8. Review of resident #34's MDS submission showed: - Admission MDS, dated [DATE], In Progress. 9. Review of resident #42's MDS submissions showed: - Annual MDS, dated [DATE], In Progress, and - Annual MDS, dated of 9/15/22, In Progress. 10. Review of resident #80's MDS submission showed: - Annual MDS, dated [DATE], In Progress. None of the submissions for resident #s 23, 42, and 80's Annual MDS and resident #23's Admission MDS had Care Area Assessments identified or triggered, which led to inadequate care plan focus areas. 45448 11. Review of resident #48's MDS submission showed: -Admission, dated 8/2/22, In Progress. 12. Review of resident #79's MDS submission showed: -Admission, dated 1/13/22, In Progress. 13. Review of resident #47's MDS submission showed: -Annual, dated 7/31/22, In Progress. During an interview on 9/14/22 at 7:59 a.m., staff member F stated the facility was aware of the problems with completing the MDSs for the residents. Staff member F said, We try to get MDS done as we can, and as we have time.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997 Based on interview and record review, facility staff neglected to complete quarterly assessments every three months for 7 (#s 7, 12, 34, 47, 73, 78, and 79) of 14 sampled residents. Findings include: 1. Review of resident #73's MDS (minimum data set) list, in the resident's EMR (electronic medical record), showed the facility transmitted the following assessments to CMS (Center for Medicare and Medicaid Services)- - PPS 5 Day, dated 1/3/22, and - Quarterly, dated 8/23/22. Facility staff had not completed a Quarterly MDS assessment between 1/4/22 to 8/22/22. 2. Review of resident #78's MDS list, in the resident's EMR, showed the facility transmitted the following assessments to CMS- - Entry Record, dated 5/9/22. Facility staff had not completed a Quarterly MDS assessment after 5/10/22. 3. Review of resident #7's MDS list, in the resident's EMR. showed the facility transmitted the following assessments to CMS- - Admission, dated 5/4/22. Facility staff had not completed or transmitted another MDS from 5/5/22 to 9/13/22. 4. Review of resident #12's MDS list, in the resident's EMR, showed the facility transmitted the following assessments to CMS- - Admission Assessment, dated 5/3/22. Facility staff had not completed or transmitted another MDS from 5/4/22 to 9/13/22. During an interview on 9/14/22 at 7:59 a.m., staff member F said facility staff were aware completing and transmission of the MDS assessments was an on-going problem, and had been for quite awhile. Staff member F said, We try to get MDS done as we can and as we have time. 41951 5. Review of resident #34's MDS submissions showed: - Quarterly MDS, dated [DATE], In Progress. (continued on next page)

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	275103	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45448 6. Review of resident #47's MDS submissions showed: - Quarterly MDS, dated [DATE], In Progress, - Quarterly MDS, dated [DATE], In Progress. 7. Review of resident #79's entry MDS submissions showed: - Quarterly MDS, dated [DATE], In Progress, and - Quarterly MDS, dated [DATE], In Progress.

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	275103	A. Building B. Wing	09/16/2022

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997 Based on interview and record review, facility staff failed to complete and transmit Minimum Data Set information in the time specified by the Center for Medicare and Medicaid Services for 15 (#s 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 23, 34, 42, and 80) of 16 sampled residents. Findings include: During an interview on 9/13/22 at 9:46 a.m., staff member B said MDS assessments were identified as a concern in February (2022). Staffing was an issue, and the facility had not been able to keep an MDS coordinator on staff. 1. Review of resident #6's MDS (minimum data set) list in the EMR (electronic medical record) showed a Return not anticipated MDS, dated [DATE], started but not completed or transmitted. 2. Review of resident #5's MDS list in the EMR showed a Return Anticipated MDS, dated [DATE], was not completed or transmitted. 3. Review of resident #3's MDS list in the EMR showed a Quarterly MDS, dated [DATE], a Medicare 5 Day MDS, dated [DATE], and End of PPS Part A Stay MDS, dated [DATE], were not completed or transmitted. 4. Reveiw of resident #11's MDS list in the EMR showed a Discharge Return Not Anticipated MDS, dated [DATE] was not completed or transmitted. 5. Review of resident #4's EMR showed the resident discharged from the facility on 5/9/22. Review of resident #4's MDS list in the EMR showed a Medicare 5 Day Assessment, dated 4/13/22 was submitted. Facility staff failed to complete and transmit a Discharge MDS for this resident. 6. Review of resident #7's EMR showed the resident discharged from the facility on 5/19/22. Review of resident #7's MDS list in the EMR showed facility staff failed to complete and transmit a Discharge MDS for this resident. 7. Review of resident #9's EMR showed the resident discharged from the facility on 5/18/22. Review of resident #9's MDS list in the EMR showed facility staff failed to complete and transmit a Discharge MDS for this resident. 8. Review of resident #12's MDS list in the EMR showed facility staff completed a Quarterly MDS, dated [DATE], had not been transmitted. 9. Review of resident #8's EMR showed the resident was discharged from the facility on 6/10/22. Review of resident #8's MDS list in the EMR showed facility staff completed a Discharge Return Not Anticipated MDS, dated [DATE], had not been transmitted. The status of the MDS was In Progress. (continued on next page)

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	275103	A. Building B. Wing	09/16/2022

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	10. Review of resident #1's EMR showed the resident was discharged from the facility on 4/8/22. Review of resident #1's MDS list in the EMR showed the facility had not completed or transmitted an Admission MDS, dated [DATE]. Facility staff failed to complete and transmit a Discharge Return Not Anticipated MDS, dated [DATE], also. 11. Review of resident #2's EMR showed the resident was discharged from the facility on 4/16/22. Review of resident #2's MDS list in the EMR showed the facility had not completed and transmitted the Return Not Anticipated MDS, dated [DATE]. 41951 12. Review of resident #23's MDS submissions showed: - Annual MDS, dated [DATE], In Progress, - Quarterly MDS, dated [DATE], In Progress, and - Annual MDS, dated [DATE], In Progress. 13. Review of resident #34's MDS submissions showed: - Admission MDS, dated [DATE], In Progress, and - Quarterly MDS, dated [DATE], In Progress. 14. Review of resident #42's MDS submissions showed: - Annual MDS, dated [DATE], In Progress, - Quarterly MDS, dated [DATE], In Progress, and - Annual MDS, dated [DATE], In Progress. 15. Review of resident #80's MDS submissions showed: - Quarterly MDS, dated [DATE], In Progress, - Quarterly MDS, dated [DATE], In Progress, and - Annual MDS, dated [DATE], In Progress. Review of resident #s 23, 34, 42, and 80's MDS list in their EMR, showed their MDS's had not been transmitted.

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	275103	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45448 Based on interview, and record review, the facility failed to complete accurate Admission and Quarterly assessments for 3 (#'s 48, 49, and 73) of 6 sampled residents. This deficient practice had the potential to affect resident care and safety. Findings include: During an interview on 9/14/22 at 12:33 p.m., staff member J stated it was the admitting nurse's responsibility for completing the initial nursing assessment on new admissions. Staff member J said the admitting nurse refused to do the admission assessment for resident #49, and left it for day shift to complete. Staff member J said she was the day shift nurse and was unable to complete the assessment back in the secured unit because she was too busy out on the floor with other residents. 1. Record review of resident #49's Admission/Readmission Assessment, nursing admission assessment, showed an admitted [DATE], and an admission assessment completion date of 9/13/22, after the document was requested. Resident #49 did not have an admission nursing assessment completed to establish a baseline for directing care for resident #49. 2. A record review of resident #48's MDS showed, a Entry date of 7/26/22. A request was made for resident #48's nursing admission assessment documentation on 9/14/22. No documentation was provided by the end of the survey. Resident #48 did not have an admission nursing assessment completed to establish a baseline for directing care for resident #49. The wound on resident #49's right lower leg was not assessed for size and type to direct the care and treatment of resident #49's wound. Record review of a facility policy, Admission Notes, dated September 2020, showed: . Preliminary resident information shall be documented upon a resident's admission to the facility. Policy Interpretation and Implementation 1. When a resident is admitted to the nursing unit, the admitting Nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol: a. The date and time of the resident's admission; b. The resident's age, sex, race, and marital status; c. From where the resident was admitted (i.e., hospital, home, other facility); d. Reason for the admission; e. The admitting diagnosis; f. The general condition of the resident upon admission; (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	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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F 0641 Level of Harm - Actual harm Residents Affected - Few	g. The time the Attending Physician was notified of the resident's admission; h. The time the physician's orders were received and verified; i. Description of any lab work completed or the time specimens were sent to the lab; j. The presence of a catheter, dressings, etc.; k. The time the Dietary Department was notified of the diet order; l. The time medications were ordered from the pharmacy; m. A brief description of any disabilities (i.e., blind, deaf, hemiplegia, speech impairment, paralysis, mobility, etc.); n. Any know allergies; o. Prosthesis required (i.e., glasses, dentures, hearing aid, artificial limbs, eye, etc.); p. The height and weight of the resident; q. A statement indicating that the nursing history and preliminary assessment is completed or has been started; r. Notation of any signs or symptoms of infectious or communicable disease; s. Notation as to whether or not advance directives apply; and t. The signature and title of the person recording the data. 32997 3. Review of resident #73's Medicare- 5 Day MDS, with an ARD of 1/3/22, Section K, showed the resident weighed 204 pounds. Review of resident #73's Quarterly MDS, with an ARD of 8/23/22, Section K, showed the resident weighed 164 pounds, and the section was marked unknown if resident #73 had a weight loss. Resident #73 had lost 40 pounds or 19.61%, an insidious, severe weight loss between the 5 day MDS and the Quarterly MDS. Facility staff failed to identify the severe weight loss for resident #73 on his Quarterly MDS, with an ARD of 8/23/22. During an interview on 9/13/22 at 9:46 a.m., staff member B said MDS assessments were identified as a concern in February (2022), and the facility was trying to employ an MDS coordinator. During an interview on 9/14/22 at 2:38 p.m., staff member G said he completed section K of the MDS. (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	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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F 0641 Level of Harm - Actual harm Residents Affected - Few	During an inteview on 9/15/22 at 9:16 a.m., staff member B said she understood if facility staff failed to complete the assessment process for a resident facility staff would not be able to indentify and provide the care needed for the residents residing in the facility.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45448 Based on observation, interview, and record review, the facility failed to identify resident care concerns; and failed to develop and implement a baseline care plan for 1 (#74) of 3 sampled residents. Findings include: During an observation and interview on 9/12/22 at 10:29 a.m., resident #74 said she was admitted on [DATE] for care after having surgery on her right rotator cuff. Resident #74's door was labeled with a droplet/contact isolation precaution sign. A PPE cart was outside of resident #74's door. During an interview on 9/12/22 at 1:19 p.m., staff member A said the facility had not had an MDS/care plan individual since February 2022. Record review of resident #74's EMR showed no baseline care plan records were found. A request was made for resident #74's baseline care plan was made on 9/12/22. No documentation was provided by the end of the survey. A baseline careplan for resident #74 following shoulder surgery would be expected to address pain control, dressing/wound care, range of motion, ADL's and physical limitations.

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
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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** 32997 Based on interview and record review, facility staff neglected to develop and implement person-centered, comprehensive care plans for 5 (#s 48, 73, 77, 78, 79) of 6 sampled residents. Findings include: 1. Review of resident #73's MDS submissions showed: - Admission MDS, with an ARD (assessment reference date) of 11/24/21, In Progress. Facility staff failed to complete a comprehensive assessment for resident #73. Due to that failure, facility staff was unable to complete a comprehensive care plan for resident #73. 2. Review of resident #78's MDS submissions showed: - Admission MDS, with an ARD of 5/14/22, In Progress. Facility staff failed to complete a comprehensive assessment for resident #78. Due to that failure, facility staff was unable to complete a comprehensive care plan for resident #78. 3. Review of resident #77's MDS submissions showed: - Admission MDS, with an ARD of 8/24/22, In Progress. Facility staff failed to complete a comprehensive assessment for resident #77. Due to that failure, facility staff was unable to complete a comprehensive care plan for resident #77. 45448 4. Review of resident #48's MDS submissions showed: - Admission MDS, dated [DATE], In Progress. Facility staff failed to complete a comprehensive assessment for resident #48. Due to that failure facility staff was unable to complete a comprehensive care plan for resident #48. 5. Review of resident #79's MDS submissions showed: - Admission MDS, dated [DATE], In Progress. Facility staff failed to complete a comprehensive assessment for resident #79. Due to that failure facility staff was unable to complete a comprehensive care plan for resident #79.

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	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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F 0657 Level of Harm - 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. 32997 Based on interview and record review, the facility neglected to revise care plans to ensure a person-centered care plan with appropriate goals and interventions for a severe weight loss was in place for 2 (#s 73 & 78) of 6 sampled residents; and failed to ensure appropriate focus areas for anxiety and side effects of an anticoagulant medication were in place for 1 (#34) of 6 sampled residents. Findings include: 1. Review of resident #73's weight record, from 1/9/22 to 6/23/22, showed, the resident had lost 40 pounds in six months. This was a severe weight loss of 19.7%. Review of resident #73's Nutrition Care Plan, date initiated 11/24/21, and date revised 11/24/21, showed: - Focus -Nutrition: Potential for alteration in nutritional status r/t (related to) history of COPD, upper and lower dentures (currently fit with concerns). - Goal: - Maintain weight without significant weight change through the review period. Date initiated 11/24/21, revised on 8/8/22, with a target date of 11/8/22. - Interventions/Tasks: - 2 Liter Fluid restriction. Date Initiated: 11/24/2021, - Allow enough time for the resident eat, date initiated 11/24/21, - Boost or Ensure BID (twice a day), prefers strawberry flavor best, date initiated 1/5/22, - Dietitian (sic) consults prn (as needed), date initiated 11/24/21, - Encourage resident to eat 75-100%, date initiated 11/24/21, - Offer sandwich and additional snacks daily to ensure adequate protein and calorie intakes, dated initiated 12/29/21, - Offer substitute if less that 50% of meal consumed, date initiated 11/24/21, and - Provide regular diet, date initiated 11/24/21, and Weigh per facility order, date initiated 11/24/21. (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	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Actual harm Residents Affected - Few	Resident #73's severe weight loss was not identified by facility staff. Facility staff neglected to update and implement a person-centered care plan with measurable goals and interventions for resident #73's severe weight loss. During an interview on 9/15/22 at 3:30 p.m., staff member V said there was a sign posted on the wall, by the nursing station, to tell staff to give residents a supplement if they only ate a percentage of their meals. Staff member V said she did not have access to resident care plans in the EMR. 2. Review of resident #78's monthly weight record, from 5/10/22 to 6/23/22, showed, the resident had a weight loss of 14 pounds in a month. This was a severe loss of 6.74%. Review of resident #78's care plan failed to show a nutrition care plan with focus, goals, and interventions to address the severe weight loss for the resident. Resident #78's severe weight loss was not identified by facility staff. During an interview on 9/14/22 at 2:38 p.m., staff member G said he ran weight reports, showing 30, 60, and 90 day weights for the residents with trending of weight losses or gains for the nutrition at risk team. Staff member G said the nutrition at risk team had not met in a long time. Staff member G said he completed Section K of the MDS, and he wrote the nutrition care plans for the residents. 41951 2. Review of resident #34's MAR, printed on 9/15/22 at 10:19 a.m., showed diagnoses which included, but were not limited to, Chronic Atrial Fibrillation and Anxiety Disorder. Review of resident #34's MAR, printed on 9/15/22 at 10:19 a.m., showed: - Buspirone HCl tablet 20 mg, to be given by mouth, three times a day, for Anxiety Disorder, started on 5/5/22, and - Apixaban tablet 5 mg, to be given by mouth, one time a day, for Pulmonary Embolism, started on 8/1/22. Review of resident #34's care plan, as of 9/12/22, did not show any focus areas, goals, or interventions for Anxiety or possible bleeding side effects for the anticoagulant medication (apixaban). During an interview on 9/12/22 at 1:21 p.m., staff member F stated no staff had been onsite to complete the MDS's since February of 2022. Staff member F stated the same staff would also update the care plans, and since February it had been spotty.

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	275103	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - 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** 45448 Based on observation, interview, and record review, the facility failed to complete assessment and documentation for wounds present on admission for 2 residents (#s 48 and 52) of 2 sampled residents; and failed to complete the assessments and monitoring for rectal bleeding in 1 (#79) of 1 sampled resident. This deficient practice led to the failure in the facility and staff providing the quality of care residents needed. Findings include: 1. 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 with her leg and to help her to the bathroom. 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 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. Staff member J stated the resident should have been 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 completed by the facility. Staff member J said she was not always good about documenting wound care, because she gets 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 resident assessment process. The facility had been working to implement a new process but have had difficulties due to staffing issues. Record review of resident # 48's admission MDS showed an ARD of 8/8/22 showed in progress. The Admission MDS dated [DATE], 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. The facility had failed to complete assessments that would identify care areas specific to resident #48. 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 survey team. The lack of an admission assessment failed to identify the need for directed wound care on resident #48's care plan. (continued on next page)

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	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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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. During an observation and interview on 9/14/22 at 11:27 a.m., resident #52 was complaining of pain in his right lower extremity and right toe pain. Resident #52 said he had the wound on admission on 8/2/22. Staff member J assessed resident #52's dressing, it was clean, dry, and intact and had been changed the previous evening. Staff member J left the dressing in place. Staff member J examined resident #52's right great toe and found no redness or edema. Resident #52 said he had a history of an ingrown toe nail on that toe and agreed to a podiatry consult for further evaluation. Resident #52 declined the need for pain medication. Record review of resident #52's EMR showed no documentation of weekly skin checks were performed since admission on 8/2/22. A weekly skin check was performed on 9/15/22 after a request was made by the State Survey Agency. A request was made on 9/15/22 for resident #52's history and physical and physician notes for wound evaluations. No documentation was provided by the end of the survey. 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 process. The facility had been working to implement of a new process but had difficulties due to staffing issues. Review of a facility document, 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. 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 EMR or provided by the facility for resident #48 and #52. (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	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	3. 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 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, physician notification, or interventions were found. 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.

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	275103	A. Building B. Wing	09/16/2022

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 32997 Based on observation, interview, and record review, facility staff neglected to identify, and re-assess nutritional needs for severe weight loss for 3 (#s 44, 73 and 78) of 5 sampled residents. Findings include: 1. During an interview on 9/14/22 at 10:33 a.m., NF2 said expressed concerns about resident #73 not eating his meals. 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. Review of resident #73's nutritional assessments showed one, dated 11/24/21, was completed at the time of the resident's admission to the facility. A second nutritional assessment, dated 9/14/22, was provided by facility staff on 9/15/22. Review of resident #73's EMR failed to show any other nutritional assessments had been completed between 11/24/21 and 9/14/22. Review of resident #73's nursing progress notes, dated 6/20/22 to 9/13/22, failed to show the facility staff had identified a severe weight loss for the resident. Review of resident #73's nursing progress notes, dated 6/20/22 to 9/13/22, failed to show the facility had notified the resident's physician of an insidious, severe weight loss. (continued on next page)

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	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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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of resident #73's physician progress note, dated 9/14/22, showed, Staff notes some WT (weight) loss. The physician ordered an increase in resident #73's supplements. Review of resident #73's Nutrition Care Plan, date initiated 11/24/21, and date revised 11/24/21, showed: - Focus - Nutrition: Potential for alteration in nutritional status r/t (related to) history of COPD, upper and lower dentures (currently fit with concerns). - Goal: - Maintain weight without significant weight change through the review period. Date initiated 11/24/21, revised on 8/8/22, with a target date of 11/8/22. - Interventions/Tasks: - 2 Liter Fluid restriction. Date Initiated: 11/24/2021, - Allow enough time for the resident eat, date initiated 11/24/21, - Boost or Ensure BID (twice a day), prefers strawberry flavor best, date initiated 1/5/22, - Dietitian (sic) consults prn (as needed), date initiated 11/24/21, - Encourage resident to eat 75-100% date initiated 11/24/21, - Offer sandwich and additional snacks daily to ensure adequate protein and calorie intakes, dated initiated 12/29/21, - Offer substitute if less that 50% of meal consumed, date initiated 11/24/21, and - Provide regular diet, date initiated 11/24/21, and Weigh per facility order, date initiated 11/24/21. Resident #73's nutrition care plan was not revised with new focus, goals, or interventions to address his insidious, severe weight loss until 9/14/22. 2. Review of resident #78's monthly weight record showed the resident weighed 207.8 pounds on 5/10/22, and weighed 193.8 pounds on 6/23/22. That was a weight loss of 14 pounds or 6.74% in one month. That was a severe weight loss not identified by the facility. Review of resident #78's EMR failed to show a nutrition assessment had been completed for this resident. A nutritional assessment, dated 9/14/22, was provided by facility staff on 9/15/22. Review of resident #78's EMR, from 6/20/22 to 9/13/22, failed to show the resident's physician had been notified of the resident's severe weight loss. (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	09/16/2022

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of resident #78's nursing progress notes, dated 6/20/22 to 9/13/22, failed to show facility staff had identified a severe weight loss for the resident. Review of resident #78's care plan, date initiated 5/10/22, and revised on 5/17/22, failed to show nutritional concerns had been identified for the resident. During an interview on 9/14/22 at 2:38 p.m., staff member G said nutritional assessments were supposed to be completed quarterly, annually, and with a significant change. Staff member G said he would complete a nutritional assessment at the time of a resident's admission. 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 in the past he had gotten notifications from the MDS coordinator when the MDSs, nutritional assessments, and care plans for residents were due. Staff member G said the facility did not have an MDS coordinator at the time and there had not been one for quite some time. 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 the facility provided various nutritional liquid drinks to residents that did not complete their meals or had weight loss, but these would be ordered by the physician after discussion with staff. Staff member G said the facility had not provided fortified diets to at risk residents in the past, but it was something facility staff had recently discussed. 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 throughout the dining observation. She did not take a bite of the corn dog and did not eat any of the food from the meal 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 get resident #44 to sit at a table in the dining room to eat. 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 throughout 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 it while wandering in the unit. During an interview on 9/14/22, at 11:18 a.m., staff member I said she was not aware of any supplements dietary supplements ordered for resident #44 and if she likes things, she would eat them. Staff member I said resident #44 had not been eating well for the last month. She had not reported it to nursing staff. (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	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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F 0692 Level of Harm - Actual harm Residents Affected - Few	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, 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. If a concern was identified, a significant change would be done in the MDS. 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 severe weight loss that resulted in a 8.15% weight loss. 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. Review of a facility document, Nutritional Assessment, dated 9/14/22, showed: . Nutritional history: Weight, diet, dining habits: Resident intake remains variable between 25-75% of meals as charted. Able to feed self at most times with minimal assistance. Weight has significantly decreased over 6 months with weight loss of 12.7 lbs. or 10.4%. Resident ordered finger foods and she typically will eat while pacing. . Summary: Resident has had significant weight loss of 10.4% over 6 months. Switched to finger foods at RN's request due to consistently moving while eating and resident unable to intake most meals requiring utensils. All food is ordered to be served in bowls as resident is able to carry food and eat while pacing. Resident reviewed at nutrition at risk meeting on this date, intervention of ensure with meals initiated. Review of resident #44's care plan with an initiation date of 11/9/19 and revision date of 8/22/22, under focus area showed: Nutrition: Potential for alteration in nutritional status . .At risk for Inadequate Nutrition r/t: history of variable po intake; dementia dx; constant movement/pacing. . Goal: Resident will consume 75% or greater at meal times. Resident will maintain weight at 120lbs +/- 10 lbs. Revision on 8/22/22 . .Interventions: -All meals to be served in bowls, cut up meat, (resident #44) prefers finger foods if available. Initiated: 4/19/21 . .Monitor for changes in nutritional status (change in po intake ability, feed self, unplanned wt loss/gain, abnormal labs) and report to RD/MD as indicated. Initiated 11/9/2019 . Resident #44's care plan showed resident #44 was to receive her meals cut up and in bowls and any change in intake was to be reported to the registered dietician and the physician. Resident #44's food was not always cut up and her decrease in intake was not reported to the registered dietician or the physician. (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	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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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy Weight Assessment and Intervention, revised on September 2008, showed: - Weight Assessment- . 5. The Dietitian (sic) will review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met. 6. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight) / (usual weight) x 100]: a. 1 month - 5% weight loss is significant; greater that 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; great than 10% is severe. - Care Planning- 1. Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the Physician, nursing staff, the Dietitian (sic), the Consultant Pharmacist, and the resident or resident's legal surrogate. 2. Individualized care plans shall address, to the extent possible: a. The identified causes of weight loss; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment. - Interventions- 1. Interventions for undesirable weight loss shall be based on careful consideration of the following: a. Resident choice and preferences; b. Nutrition and hydration needs of the resident; c. Functional factors that may inhibit independent eating; d. Environmental factors that may inhibit appetite or desire to participate in meals; e. Chewing and swallowing abnormalities and the need for diet modifications; (continued on next page)

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	275103	A. Building B. Wing	09/16/2022

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F 0692 Level of Harm - Actual harm Residents Affected - Few	f. Medications that may interfere with appetite, chewing, swallowing, or digestion; g. The use of supplementation and/or feeding tubes; and h. End of life decisions and advance directives.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 45448 Based on observation, interview, and record review, facility staff failed to identify and provide behavioral health interventions; and failed to track and document disruptive behaviors within the Solana (secure) unit for 1 (#44) of 1 sampled resident. Findings include: During an interview on 9/12/22 at 11:35 a.m., NF4 said resident #44 frequently screamed out and made it difficult for other residents living in the secured unit. Due to resident #44's disruptive behaviors in the dining room most of the other residents ate in their rooms. During an observation and interview on 9/13/22 at 12:37 p.m., resident #44 was wandering in and out of the dining area. Resident #44 was very loud, babbling, and laughing. Staff member L said resident #44 was often loud with her noises. Staff member L said other residents would complain, and the staff would try to redirect resident #44. A resident was seated at a table eating her lunch. She asked resident #44 to stop making noises. Resident #44 left the dining room, and another resident commented, Silence is golden. During an observation on 9/13/22 at 12:57 p.m., resident #44 was wandering through the unit, being very loud, repeating words, and making noises. Resident #44 walked into the dining room, grabbed another resident, and would not let go. Staff member L intervened, redirecting resident #44. Staff member L forced resident #44 to release the other resident. Staff member M then guided resident #44 away from the other residents and toward the dining room door. Resident #44 leaned over staff member L, who was assisting a resident eating her meal, let out a very loud noise and had an aggressive grimace on her face. Staff member M quickly directed resident #44 from the dining room. A request was made on 9/12/22 for resident #44's physician evaluations and notes on behaviors identified and exhibited, and behavior monitoring notes. A request was again made on 9/15/22 for any notes on resident #44's behaviors. No documentation was provided by the end of the survey. During an interview on 9/15/22 at 8:24 a.m., staff member F said resident #44 was only being monitored for signs of depression, side effects of her medications, and the amount of time she sleeps. Her behaviors were not being monitored. Record review of resident #44's care plan showed: Focus: - [Resident #44] has no awareness of safety, or boundaries related to other's personal space. [Resident #44] exhibits difficulty with behavioral issues as evidenced by wandering and being resistant to cares. - [Resident #44] has attempted to and punched random people without provocation. Date initiated: 11/12/19. Revision on: 12/21/2021 Goals: (continued on next page)

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	275103	A. Building B. Wing	09/16/2022

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- [Resident #44] will respond to redirection with no episodes through the review date. Date initiated: 11/12/2019. Revision date: 04/05/2022. Target date: 11/24/2022, and - [Resident #44] will have no verbal of physical outbursts towards other thru the review date. Date initiated: 11/12/2019. Revision on 04/05/2022. Target date: 11/12/2022. Interventions: - Invite/encourage to attend activities Date Initiated: 11/12/2019 - Medicate as ordered. Date Initiated: 11/12/2019 - Monitor every shift for episodes described behavior and record on medication sheet. Date Initiated: 11/12/19 . - Staff will redirect from maladaptive behaviors resident with verbal interventions, snacks and beverages. Date Initiated: 11/12/2019 . Resident #44's care plan did not show revisions or additional interventions for resident #44's disruptive behaviors after the date the care plan was initiated. Resident #44 displayed behaviors that were disruptive to other residents withing the secured unit.

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	275103	A. Building B. Wing	09/16/2022

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45448 Based on observation, interview and record review, the facility failed to ensure sufficient staffing to provide the necessary care and services for; resident supervision and monitoring of behaviors in the memory care unit for 7 (#'s 43, 44, 47, 48, 49, 52 and 79) of 11 sampled residents; for resident wound assessments and documentation for 2 (#'s 48 and 49) of 2 sampled residents; for admission assessments for 2 (#'s 48 and 49) of 4 sampled residents. Findings include: Supervision and Monitoring 1. During an observation on 9/12/22 at 11:28 a.m., resident #48 wandered into resident #43's room. No staff were observed in the unit hallway monitoring or supervising residents for approximately five minutes. During an interview on 9/12/22 at 11:35 a.m., NF4 said the staffing was very short. NF4 stated the facility staffed the secure unit with a CNA and another aide. NF4 said staff would eat in the kitchen area while watching the residents. NF4 said she observed this daily because she was in the unit every day with resident #49. 2. During an observation and interview on 9/12/22 at 12:23 p.m., a meal tray cart arrived on the unit. Staff member L rolled the cart into the dining area. Residents #44, #47, #48, #52 and #79 were in the dining room. Resident #52 said to watch resident #79. Resident #52 said resident #79 would often help himself to the other resident trays because the staff were busy delivering trays and there was no on available to stop him. Resident #79 wheeled over to the dining cart and helped himself to applesauce from another resident's tray. Staff members were not present in the dining room monitoring or supervising residents. Staff member L and staff member M were delivering meal trays to resident rooms. During an interview on 9/13/22 at 1:23 p.m., staff member L said the secured unit was usually staffed with one CNA and one hospitality aide. Nurses came to the secured unit to pass scheduled medications and if the aides called for PRN medication. Staff member L said sometimes it was enough staff, but other times when residents had behavior issues, it was difficult. During an interview on 9/13/22 at 2:07 p.m., staff member F said staffing for the secured unit had been one CNA and a hospitality aide. Staff member F said the facility had staffing issues and she did not want to leave the unit with just one CNA. Staff member F said, Ideally, she would like the secured unit to be staffed with one CNA and a nurse. Staff member F said the facility had been short staffed. (continued on next page)

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	275103	A. Building B. Wing	09/16/2022

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation and interview on 9/14/22 at 9:00 a.m., resident #52 said, You should have been here this morning before they served breakfast. There were no staff keeping an eye on these two (residents #44 and #47) and they got into fisticuffs. There was no one to break it up. Resident #52 said he was seated by the dining room door to keep an eye on them so they don't get into it again. Resident #52 said he was waiting for management to talk to someone about the situation. No staff members were observed in the unit hallways or dining area monitoring or supervising residents upon entry to the secured unit and while speaking to resident #52. Staff member H was in a resident room changing the bedding and staff member I was assisting a resident with a shower. During an interview on 9/14/22 at 11:18 a.m., staff member H and staff member I said they tried to make sure one staff member was always observing residents. Staff member H said it was not always possible because it was busy on the unit. During an interview on 9/14/22 at 12:33 p.m., staff member J said, I am always doing showers and passing medications. I am supposed to do all the admissions too. I don't have time. They really need a nurse in the (secured) unit because things happen, and I am all the way over here (A and B wing) with other residents. I can't always respond. I feel it is a safety issue. During an interview on 9/14/22 at 1:58 p.m., staff member B said staffing was identified as an issue on the secured unit. It was decided to place a CNA and a hospitality aide on the unit. Staff member B said the facility had done a lot of education of CNAs on monitoring, care, and safety of residents. Record review of a facility document, Behavioral Assessment, Intervention and Monitoring, dated December 2016 showed: . 11. The Director of Nursing, or designee, will evaluate whether the staffing needs have changed based on acuity of the residents and their plans of care. Additional staff and/or staff training will be provided if it is determined that the needs of the residents cannot be met with the current level of staff or training. Wound Assessment 1. 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. During an interview on 9/14/22 at 1:38 p.m., staff member J stated resident #48 should have been sent to the wound clinic. Staff member J did not know why resident #48 had not been sent to wound clinic. Staff member J said she was not always good about documenting resident #48's wound because she got busy with other residents. 2. During an observation and interview on 9/14/22 at 11:27 a.m., resident #52 said he had the right lower leg wound present on admission on 8/2/22. Staff member J was observed assessing resident #52's dressing, which was clean, dry, and intact. Staff member J said it had been changed the previous evening. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of resident #52's EMR showed no documentation of weekly skin checks being performed since his admission on 8/2/22. A weekly skin check was performed on 9/15/22 after a request was made by the State Survey Agency. During an interview on 9/14/22 at 1:58 p.m., staff member B said the secured unit opened April 2022. The facility had identified an issue with the nursing assessment processes on the secured unit. The facility had been working to implement new processes but had difficulties due to staffing. Admission Assessments 1. Record review of resident #49's Admission/Readmission Assessment, showed an admitted [DATE] with an admission assessment completion date of 9/13/22. This occurred after the document was requested on 9/13/22 at 1:42 p.m. During an interview on 9/14/22 at 12:33 p.m., staff member J stated it was the admitting nurse's responsibility to complete the initial nursing assessment for newly admitted residents. Staff member J said the admitting nurse refused to do the admission assessment for resident #49 and left it for day shift to complete. Staff member J said she was the day shift nurse and was unable to complete the assessment on the secured unit because she was too busy on the main units with other residents. 2. Resident #48 was admitted to the facility on [DATE]. A request was made for resident #48's nursing admission assessment documentation on 9/14/22. No documentation was provided by the end of the survey.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951 Based on interview and record review, the facility failed to provide nonpharmacological interventions for a resident diagnosed with dementia for 1 (#34) of 6 sampled residents. Findings include: During an interview on 9/12/22 at 1:21 p.m., staff member F stated no staff had been onsite to complete the MDS's since February of 2022. Staff member F stated the same staff would also update the care plans, and since February it had been spotty. During an interview on 9/15/22 at 10:36 a.m., staff member Q stated she had never seen a care plan for any of the residents and did not know where they were located. Staff member Q stated she had been trained in dementia care but did not have an individualized plan to follow for each resident. Staff member Q stated she just used interventions she thought would work to help the residents. During an interview on 9/15/22 at 10:41 a.m., staff member R stated she had training in dementia, but did not know which residents had individualized plans for dementia. Review of the MDS submissions on 9/15/22 showed resident #34 had been admitted on [DATE]. The MDS submissions since resident #34 was admitted had not been transmitted and were labeled, In Progress. The Quarterly MDS submission that was Accepted was dated 8/18/22, but did not have any care area assessments identified or triggered. Review of resident #34 had diagnoses including Alcohol use, unspecified with alcohol-induced persisting Dementia. Review of resident #34's September 2022 MAR, printed on 9/15/22 at 10:19 a.m., showed: - Donepezil HCl tablet 10 mg, to be given by mouth, in the evening, for Dementia, started on 2/12/22, and - Memantine HCl tablet 10 mg, to be given by mouth, two times a day, for Dementia, started on 2/13/22. Review of resident #34's care plan, as of 9/12/22, had not identified dementia as a focus area. Due to dementia not being identified, there was no individualized care plan to maintain resident #34's highest practicable physical, mental, and psychosocial well-being.

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	275103	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32997 Based on observation, interview, and record review, kitchen staff failed to follow menus for meals served, and failed to address the menu changes with a registered dietician. Findings include: During an observation on [DATE] at 12:46 p.m., residents were being served lunch. Lunch was sliced ham and scalloped potatoes. The menu showed candied yams. During an observation on [DATE] at 8:01 a.m., residents were being served breakfast. Breakfast was an omelet and a donut. The menu showed coffee cake. During an interview on [DATE] at 11:35 a.m., staff member U said if the kitchen did not have an item the menu called for, he would substitute something else. Staff member U said he had been cooking at the facility since December of 2021. During an interview on [DATE] at 2:38 p.m., staff member G said he would have to approve any menu changes or substitutions before the food was served to the residents. Staff member G was not aware scalloped potatoes had been exchanged for the candied yams on [DATE]. During an interview on [DATE] at 8:23 a.m., staff member U did not know he needed approval from the dietician prior to substituting an item on the menu.

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	275103	A. Building B. Wing	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32997 Based on observation, interview, and record review, the facility failed to provide food that was served in a timely manner, and that was hot, palatable, and of a pleasing appearance for 3 (#s 12, 17, and 72) of 6 sampled residents. Findings include: During an interview on 9/12/22 at 11:35 a.m., NF4 said the food did not arrive in a timely manner. NF4 said no menus were provided so no one ever knew what would be served. NF4 said if the alternate meal was chosen it took another 20 to 30 minutes for the resident to get it from the kitchen. During an interview on 9/12/22 at 11:44 a.m., resident #17 said the meals were always over-salted. He said the vegetables were always over-cooked, and were just nasty. During an interview on 9/12/22 at 4:09 p.m., resident #12 said the food was not good, and it was always served late. Resident #12 said food was consistently 30 to 45 minutes late. Review of the facility's dining times showed meals were to be served at 8:00 a.m., 12:00 p.m., and 5:00 p.m During an interview on 9/14/22 at 8:27 a.m., NF1 said residents had a lot of complaints about the food. NF1 said the complaints included cold food, burnt food, inedible food, and food being served late. NF1 said the residents had given up complaining to facility staff about the food because nothing ever happens. During an observation on 9/14/22 at 8:29 a.m., breakfast had not been served. The dining cart was located in the hallway. Resident #72 had been waiting in the dining room since 7:50 a.m A staff member served resident #72's tray at 8:37 a.m Review of resident council minutes, dated 9/13/22, showed residents had concerns of the food being cold when served. Review of resident council minutes, dated 3/15/22, showed residents had concerns of the food being burnt and cold when it was served. During an interview on 9/14/22 at 9:40 a.m., staff member U said he had been a cook at the facility since December 2021. Staff member U said after breakfast is done he starts preparing for lunch. Staff member U said as food is cooked he puts it in the oven to keep it hot. Staff member U said usually around 11:00 a.m. he starts taking the pans out of the oven and putting them on the steam table. Staff member U said he usually starts dishing up the food onto plates around 11:30 a.m Staff member U said the dietary aide prepares the side items and the drinks. Staff member U said they (kitchen staff) try to get the food carts upstairs by Noon. Staff member U said it was up to the floor staff to get the meals to the residents in a timely manner. (continued on next page)

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	275103	A. Building B. Wing	09/16/2022

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/14/22 at 11:35 a.m., staff member U was at the steam table plating food for lunch. Staff member U removed the cover from the pan of broccoli, inserted a slotted spoon, scooped up a serving of broccoli, and placed it on a plate. The broccoli was a pale greenish yellow color, and had a rubbery appearance. During an observation on 9/14/22 at 12:12 p.m., residents were being served lunch. Several residents were heard to say the broccoli was terrible and they would not eat it.

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	275103	A. Building B. Wing	09/16/2022

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F 0835 Level of Harm - Actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41951 Based on interview and record review, the facility administrative staff, who were identified and participated in the oversight of the facility QAPI program and daily operations, failed to ensure a system and staff were in place for the timely completion of resident MDS assessments, for all residents in the facility. This failure led to the lack of the development, implementation, and revision of comprehensive care plans to address residents' care needs; and failed to identify these quality of care, system failures and act on them timely for correction. These combined deficient practices placed all 58 residents residing in the facility at risk of harm. Findings include: During the QAPI interview on 9/15/22, which started at 1:29 p.m., administrative staff members A, B, F, S, and T were present. During the interview, the administrative staff members stated they were aware of the various areas of concern and identified deficiencies, except for the infection control problems in laundry services. The administrative team failed to have an effective action plan and system process in place to track, monitor, analyze data, and re-evaluate their plan of action to address these systemic deficiencies throughout the facility. Due to the administrative team's failure to act upon and correct these areas of concerns, numerous areas of noncompliance, to include at harm level, which included (not all inclusive): - F600 - Free from Abuse and Neglect, - F636 - Comprehensive Assessments & Timing, - F641 - Accuracy of Assessments - F656 - Develop/Implement Comprehensive Care Plan, - F657 - Care Plan Timing and Revision, - F684 - Quality of Care, - F692 - Nutrition/Hydration Status Maintenance, - F741 - Sufficient/competent Staff -Behav Health Needs, and - F865 - QAPI Programming - F880 - Infection Prevention & Control. During an interview on 9/15/22 at 2:09 p.m., staff member B stated turnover in staffing was their biggest problem. Staff member B stated the turnover of staff included department managers also. Staff member B stated staff member T was added to the administrative team as the new administrator. During an interview on 9/15/22 at 2:11 p.m., staff member S stated because of the staff turnover, it had placed a hardship on the facility. (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	09/16/2022

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Continental Care and Rehabilitation	2400 Continental Dr Butte, MT 59701

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F 0835 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/15/22 at 2:14 p.m., staff member S stated the problems at the facility were not due to lack of oversight, but were due to the lack of good leadership at the department level.

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F 0865 Level of Harm - Actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 41951 Based on interview and record review, the facility failed to ensure an effective Quality Assurance Performance Improvement (QAPI) plan and process was in place to track, monitor, analyze data, and re-evaluate their plan of action to address systemic deficiencies throughout the facility as identified below: - ensure the accurate and timely comprehensive assessments, including admission, annual, and significant changes, were completed for all residents in the facility and resulting in the neglect of care for 5 (#s 44, 48, 73, 78, and 79); (see F600) - ensure the development and implementation of comprehensive care plans were completed, to address all residents' care concerns, based on the comprehensive assessments; (see F656) - ensure revisions to resident care plans were performed in a timely manner with residents' care concerns identified; (see F657) - ensure a system was in place for consistent monitoring of resident's weights to identify severe weight loss for 3 (#s 44, 73, and 78); (see F600) - ensure nursing staff consistently performed and documented skin assessments to identify altered skin integrity related to wounds for 1 (#48); (see F600, F684) - ensure nursing staff performed the admission assessment on newly admitted residents; - ensure the Infection Preventionist provided supervision and oversight of the laundry services related to proper infection prevention and control practices; (see F880) and - ensure staffing levels were adequate to meet the needs of all the residents in the facility. (see F741) Findings include: During an interview on 9/15/22 at 9:11 a.m., staff member B stated when the State Survey Agency was in the facility in July of 2022, it was discussed how the facility had identified MDS and care plan problems in February 2022. Staff member B stated the facility had not been able to get a handle on it. During an interview on 9/15/22 at 1:31 p.m., staff member A stated the QAA committee had been meeting quarterly but would now be meeting monthly. During an interview on 9/15/22 at 1:43 p.m., staff member B stated the facility currently had a performance improvement project (PIP) in place related to the MDS problem, which had been open since February of 2022. Staff member B stated three people had been in the position of MDS coordinator since February of 2022 and a new, experienced RN had started in August of 2022. She stated they had not started the evaluation and summary of the trends for the residents' MDS. Staff member B stated herself and staff member F were involved in the project and knew they were behind. (continued on next page)

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F 0865 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/15/22 at 1:46 p.m., staff member B stated care plans had been identified as a systemic problem. She stated they started with the review of memory care plans, specifically with wander risk and the secure unit placement. Staff member B stated audits had been performed for catheter, dialysis, and hospice care plans and they were now completed. No further evaluations of the remaining care plans had occurred at this time. During an interview on 9/15/22 at 1:51 p.m., staff member B stated they did not have a PIP in place for skin assessments. Staff member B stated wounds were an area of concern and a PIP was started in February of 2022. She stated they had an issue where nursing administration was reporting wound care had been done by the nurses, but they were not doing it. Staff member B stated these previous DONs had quit without notice. Staff member B stated they were aware of nurses not documenting their skin checks. She stated leadership did a skin sweep on residents (last performed in July of 2022) to make sure nurses were doing the skin checks. Staff member B stated they did not have a formal process for monitoring weights. She stated two weeks ago (approximately 9/1/22), staff member F had a meeting with all staff and baseline weights were performed on all the residents. During an interview on 9/15/22 at 1:57 p.m., staff member F stated baseline care plans and nursing admission assessments were to be performed by the nurse assigned to that unit. Staff member F stated nursing admission assessments were being performed sporadically and stated many of them were not being done upon admission. During an interview on 9/15/22 at 2:04 p.m., the inadequate infection control practices observed in laundry services related to proper PPE use and an established, contained, separate, soiled laundry area were explained to the group. Staff member B stated they were unaware of these identified concerns. Staff member B stated housekeeping/maintenance oversaw the laundry services, not the Infection Preventionist. During an interview on 9/15/22 at 2:09 p.m., staff member B stated the facility was working through a plan and process on all the areas discussed, except laundry services. Review of the facility's CASPER report, last updated 9/7/22, with a comparison to the CMS form 672, dated 9/13/22, showed the following inconsistencies: - Total number of residents residing in the facility was 43 on the CASPER report. The resident census documented on CMS form 672 showed 58 residents on 9/13/22, which was not due to new admissions. This difference in data showed the failure of timely assessment submissions. - Number of residents with an unplanned significant weight loss/gain was seven on the CASPER report. The facility reported on the CMS form 672 there were 0 residents identified with an unplanned significant weight loss/gain. This difference in the data showed the failure to identify changes in condition which had the likelihood of negative outcomes., and - Number of residents with pressure sores, excluding stage one, was one on the CASPER report. The facility reported on the CMS form 672 there were 4 residents identified with pressure ulcers which excluded stage one.

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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. 41951 Based on observation, interview, and record review, the facility failed to ensure staff member E utilized a contained, designated, dirty laundry area, to sort soiled laundry; failed to ensure staff member E donned the proper PPE while sorting soiled laundry; and failed to ensure the Infection Preventionist provided oversight for laundry services. These deficient practices had the potential to affect all residents residing in the facility. Findings include: During an observation on 9/15/22 at 7:43 a.m., staff member D stated soiled laundry was placed into a chute upstairs and then fell into a large bin in the basement. Staff member D stated most of the time the soiled laundry was placed in bags by staff, then the bags were placed in the chute. He stated some staff threw laundry, which was not bagged, with blood or feces on it, down the chute. During an observation and interview on 9/15/22 at 7:47 a.m., staff member E stated she had worked in laundry services for about a year. Staff member E was in the process of sorting soiled laundry in the same room, which contained the washers. The door to the soiled laundry room was also open to the area which contained the washers. Staff member E was only wearing a surgical mask and surgical gloves. Staff member E was not wearing any protective apron or other PPE to protect herself from the contaminated laundry. No additional PPE was observed on the hooks attached to the wall, of the dirty laundry area. No tongs/forceps or other sorting devices were observed in the dirty laundry area. During an observation on 9/15/22 at 7:52 a.m., staff member E was standing next to an overflowing bin, which contained soiled, resident's clothing. On the top of the pile of clothing located in the bin, was a piece of resident's personal clothing. The clothing had a dried, brown substance adhered to it. Staff member E pulled the piece of clothing out of the bin, and it was completely covered in thick, dried feces. All the residents' personal clothing were combined in this bin and any separating, plastic bags had been removed. During an interview on 9/15/22 at 7:58 a.m., staff member D stated he oversaw laundry services. During an interview on 9/15/22 at 2:04 p.m., staff member B stated the housekeeping/maintenance supervisor oversaw the laundry services, not the Infection Preventionist. Review of the facility's policy titled, Laundry and Bedding, Soiled, last reviewed 5/2022, showed: - .3. Place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminated items., - 4. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g., gowns if soiling of clothing is likely)., and - .12. The Environmental Services Director or supervisor will ensure that forceps/tongs or similar safe sorting devices are available for sorting laundry.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41951 Based on interview and record review, the facility failed to offer or ensure the resident's medical record contained documentation of a declination of refusal, including education regarding the benefits and potential risks associated with the influenza vaccine for 3 (#s 31, 44, and 69); and the pneumococcal vaccine for 5 (#s 31, 44, 69, 71, and 80) of 5 sampled residents. Findings include: 1. Review of resident #31's immunization records, from the State of Montana, as of 9/13/22, showed the resident had not received an influenza vaccination in 2021. The record showed resident #31 had received PPV23 on 11/18/14. During an interview on 9/13/22 at 3:06 p.m., staff member C stated there was no documentation in resident #31's medical record which showed he was offered the PCV15 or PCV20 vaccine, after the PPV23 on 11/18/14. Staff member C stated resident #31's medical record did not include a declination of refusal for the influenza vaccine in 2021 or education on the benefits and the potential risks of the vaccine. 2. Review of resident #44's medical records, on 9/13/22, showed the last time she had been vaccinated for influenza was in 2019. The record did not contain any education on the benefits and the potential risks of the influenza vaccine. No documentation was in the medical record related to pneumococcal vaccinations. During an interview on 9/13/22 at 2:47 p.m., staff member C stated the facility did not have any documentation, which showed information was given to resident #44's POA, related to the influenza vaccine in 2021. She stated there was also no documentation on any pneumococcal vaccines for resident #44. 3. Review of resident #69's medical records, on 9/13/22, showed no documentation or education related to any influenza vaccinations. There was also no documentation related to any pneumococcal vaccinations in the medical record. During an interview on 9/13/22 at 3:06 p.m., staff member C stated resident #69 had not received any influenza or pneumococcal vaccinations. Staff member C stated she did not have any refusal documentation or documented education on the benefits, or the potential risks associated with the vaccine. 4. Review of resident #71's medical records, on 9/13/22, showed she was admitted to the facility on [DATE]. No documentation related to any past vaccination records were in the medical record. During an interview on 9/13/22 at 3:12 p.m., staff member C stated resident #71 did not have documentation of a pneumococcal vaccination or a declination of refusal in her medical record. 5. During an interview on 9/13/22 at 3:06 p.m., staff member C stated no documentation was in resident #80's medical record regarding any pneumococcal vaccinations or education related to the vaccine. Review of the facility's policy titled, Influenza Vaccine, last reviewed in April of 2022, showed: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- .1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized., - .4. Prior to vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine.Provision of such education shall be documented in the resident's/employee's medical record., and - .6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record. Review of the facility's policy titled, Pneumococcal Vaccine, last reviewed in May of 2022, showed: - .1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated., - 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission., and - 3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine.Provision of such education shall be documented in the resident's medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41951 Based on interview and record review, the facility failed to maintain documentation of the refusal and the education provided to the resident or resident representative, regarding the benefits and potential risks associated with the COVID-19 vaccine for 1 (#71) of 5 sampled residents. Findings include: Review of a facility document titled, Resident COVID Vaccination Status, updated 9/6/22, showed resident #71 was listed under a column titled, Resident Refused. During an interview on 9/13/22 at 3:12 p.m., staff member C stated there was no documentation in resident #71's medical record on her refusal of the COVID-19 vaccine. Staff member C stated there was no documentation on benefits and potential risks education to the resident or the resident representative documented in the resident's medical record.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure staff are vaccinated for COVID-19 41951 Based on interview and record review, the facility failed to develop and implement policies and procedures to ensure contracted staff were fully vaccinated for COVID-19; and failed to ensure tracking and documentation was maintained on the COVID-19 vaccination status for all contracted staff. These deficient practices had the potential to affect the residents residing and the staff working in the facility, by increasing their risk of the COVID-19 infection. Findings include: Review of the facility's policy titled, COVID-19 Vaccination Policy, dated 3/13/22, did not include any information on the requirement for tracking and documenting the vaccination status of contracted staff. The facility had provided a list of contracted staff to the State Survey Agency, which had more than 18 identified External Critical Contacts companies, entities, and agencies. This list of contracted staff did not include hospice services, and did not include the vaccination status of individuals, which had the potential to enter the facility. The facility requested a list of hospice employees from the provider, with their current vaccination status, after the entrance of the State Survey Agency on 9/12/22. The hospice services company alone had 14 employees listed. During an interview on 9/14/22 at 11:37 a.m., staff member C stated the facility did not have a policy on COVID-19 vaccination status related to contracted staff. Staff member C stated there was no documentation related to tracking the vaccination status of contracted staff.