

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Bella Terra of Billings		STREET ADDRESS, CITY, STATE, ZIP CODE 1807 24th St W Billings, MT 59102	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48262</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary ADL assistance for dependent residents for bathing and showering, at least every seven days, and residents were not assisted with grooming, per observations, and this caused the residents to feel unkempt, for 3 (#s 4, 5, and 7) of 8 sampled residents for bathing and hygiene services. Findings include:</p> <p>1. During an observation and interview on 10/2/24 at 3:30 p.m., resident #7 was sitting in a wheelchair in his room. The resident's hair appeared greasy and uncombed. Resident #7 said it had been over four weeks since he had a shower, and he was to receive a shower on Mondays and Fridays, each week. Resident #7 stated, The staff were always busy just doing the things they had to do and run out of time to give showers.</p> <p>Review of resident #7's ADL/Bathing record, from 7/4/24 to 10/3/24, showed resident #7 received a shower on 7/17/24, 9/3/24, and 10/3/24. Resident #7 had gone 47 days from 7/18/24 to 9/2/24 without a shower, and 29 days from 9/4/24 to 10/2/24 without a shower. The resident missed over 30 opportunities to shower or bathe.</p> <p>2. During an interview on 10/2/24 at 3:40 p.m., resident #5 stated she had not had a shower in weeks.</p> <p>A review of resident #5's Annual MDS, with an ARD of 8/15/24, showed the resident used a wheelchair, and the resident had upper and lower extremity limitations. The resident as coded as dependent for showing and bathing, and for hygiene care the resident required substantial to maximum assistance. This showed the resident was very dependent on the care staff provided for daily for overall hygiene care and ADLs.</p> <p>Review of resident #5's ADL/Bathing record, from 9/6/24 to 10/2/24, showed resident #5 received a shower on 9/6/24. Resident #5 had gone 25 days without a shower.</p> <p>3. During an observation and interview on 10/2/24 at 3:50 p.m., the door to resident #4's room was closed. Upon opening the door, resident #4 was lying on her bed. Resident #4's hair appeared greasy and matted to her head. Resident #4 said she did not get a shower and or bed bath as often as she wanted. Resident #4 said she would like a shower or bed bath at least one time a week. Resident #4 said the facility staff were busy and that's why she wasn't getting a shower or bed bath. Resident #4 stated, It just makes me feel really dirty.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 275020
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of resident #4's Significant Change MDS, with an ARD of 8/21/24, showed the resident used a wheelchair, and the resident was coded as dependent for showers and bathing. The MDS also showed the resident provided no effort when the ADL task of bathing was completed. For hygiene, the resident was coded as a 5, meaning the resident required set up and assistance.</p> <p>Review of resident #4's ADL/Bathing record, from 7/4/24 to 10/3/24, showed resident #4 received a shower on 7/15/24, and 8/29/24. Resident #4 had gone 44 days without a shower from 7/16/24 to 8/28/24 and 34 days from 8/30/24 to 10/2/24.</p> <p>During an interview on 10/2/24 at 5:32 p.m., staff member E said she was responsible for 15 residents during her shift. Staff member E stated residents who were scheduled for a shower during her shift were, for the most part completed daily, but on occasion they could be missed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>51133</p> <p>Based on interview and record review, the facility failed to provide supervision for a resident who had a dementia diagnosis and was left at a clinic unattended which placed the resident at risk of elopement, for 1 (#8) of 3 sampled residents with a diagnosis of dementia. Findings include:</p> <p>A review of a documentation submitted to the State Survey Agency, on 8/8/24, showed resident #8 was transported to an outside medical appointment and left at the medical office, unattended, by a facility employee.</p> <p>A review of resident #8's Minimum Data Set, with an Assessment Reference Date of 7/7/24, showed the Brief Interview for Mental Status score was five, which showed the resident had severe cognitive impairment.</p> <p>A review of resident #8's care plan showed, [Resident #8] presents with wandering tendencies, is at risk for exit-seeking and wandering tendencies and [Resident #8] has a DX of UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, AND ANXIETY exhibits cognitive impairments as evidenced by period of confusion and forgetfulness, impaired decision making and judgement, impaired orientation, poor recall . [sic]</p> <p>During an interview on 10/2/24 at 3:59 p.m., NF1 stated resident #8 got a ride from [Facility Name] to the medical appointment on 8/8/24, and the resident was left unsupervised.</p> <p>During an interview on 10/3/24 at 8:00 a.m., staff member B stated, A staff member should have stayed with [Resident #8] at the medical appointment due to [Resident #8's] severe cognitive impairment.</p> <p>During an interview on 10/3/24 at 8:40 a.m., staff member D stated, I'm not supposed to stay (with residents). I drop them (the residents) off and continue about my day.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48262</p> <p>Based on observation, interview, and record review, the facility failed to have necessary catheter supplies available, and therefore supplies were used which caused an allergic reaction, and failed to notify the medical provider in a timely manner, for 1 resident (#6) of 3 sampled residents with catheters. Findings include:</p> <p>During an observation and interview on 10/2/24 at 4:40 p.m., resident #6 was sitting in a wheelchair in his room. Resident #6 had a covered catheter bag hanging on the underside of the wheelchair. Resident #6 stated he developed a rash after his suprapubic catheter was replaced, at the end of August. Resident #6 stated his catheter was changed two times within a week, at the end of August, because it was pulled, and the nurse was not able to flush it. Resident #6 stated a silver tip catheter is the only one that works because he is allergic to several different (catheter) materials.</p> <p>Review of resident #6's electronic medical record document, titled Clinical Allergy, dated 10/30/21, showed, Allergen: silicone foley catheter, Allergy type: Allergy, Severity: Moderate, Reaction note: Blisters. [sic]</p> <p>Review of resident #6's electronic medical record nursing progress note, dated 8/28/24 at 5:39 p.m., showed, Suprapubic catheter clogged. Unable to flush so Suprapubic cath changed using 18 fr silicone. 10 cc balloon per resident. When old foley removed, massive amount of urine gushed out. Upon replacement, no urine back flow noted. Will monitor closely. [sic]</p> <p>Review of resident #6's electronic medical record nursing progress note, dated 8/29/24 at 11:16 a.m., showed, Called and spoke with nurse at providers office regarding catheter. providers office aware of current Cath in place. This Ln is working on finding a silver coated Cath for resident. Resident placed on alert and will continue to monitor. [sic]</p> <p>Review of resident #6's electronic medical record nursing progress note, dated 8/29/24 at 11:23 a.m., showed, LATE ENTRY New Suprapubic cath placed per MD order to new brand recommended by MD Silicone cath removed, area cleansed per protocol. Resident tolerated well. New 18F 19cc [NAME] placed without complications. Draining clear yellow urine to gravity. [sic]</p> <p>Review of resident #6's electronic medical record nursing progress note, dated 8/29/24 at 1:42 p.m., showed, Resident presenting with rash to upper body possibly related to use of Silicone catheter that resident is allergic to. New order received from MD for cath change as well as benadryl and prednisone First dose of prednisone administered will continue to monitor for ASE or worsening condition. [sic]</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/3/24 at 4:24 p.m., Staff member F stated she replaced resident #6's super pubic catheter on 8/28/24. Staff member F stated she was notified by a CNA on 8/28/24 resident #6 had no urine output for the day. Staff member F stated she assessed the resident, and he had complained of pelvic pain and pressure. Staff member F stated she attempted to flush resident #6's catheter stating, It was like cement. Staff member F stated she removed the catheter and the resident's bladder was able to empty. Staff member F stated, I used what (catheter) was available at the time. Staff member F stated she was not aware resident #6 had an allergy to silicone and assumed silicone was hypoallergenic. Staff member F stated she did not contact the medical provider's office after inserting the silicone catheter, but did relay resident #6's catheter was changed to the incoming nurse during shift report on 8/28/24 at 6:37 p.m.</p>